New Patient Sleep Questionnaire

(If you have already done a questionnaire as part of a sleep clinic or sleep study evaluation please let the staff know. You do not have to fill out another questionnaire. Please let them know if there have been any interval changes in medications or medical history)

Patient Name: __________________________ Date: __________________________

Referring MD: __________________________ PCP: __________________________

Insurance: __________________________ Date of Birth: __________________________

Pharmacy: __________________________ Best Phone number: __________________________

Age: ____ Sex: Male / Female Height: ____ (inches) Weight: ____ (lbs.) Neck size: ____ (inches)

What is the reason you are being referred? ____________________________________________________________

Epworth Sleepiness Score: How likely are you to doze in the following situations?
0 = Never 1 = Slight Chance 2 = Moderate Chance 3 = High Chance

___ Sitting & reading
___ Watching television
___ Sitting inactive in a public place (i.e. theater)
___ Passenger in a car for an hour without a break
___ Lying down to rest in the afternoon
___ Sitting and talking to someone
___ Sitting quietly after lunch without alcohol
___ In a car while stopped for a few minutes in traffic
___ Total Score

Sleep Schedule: Weekdays (school/work days) Weekends

What time do you usually go to bed? __________ __________
What time do you usually wake up? __________ __________

Do you usually take a nap? For how long? __________ __________

1. How many **hours do you usually sleep** at night? __________ Hours

**NOTE:** 0 = Never 1 = Rarely 2 = Sometimes 3 = Frequently N/A = not applicable

2. Do you have **difficulty falling asleep**? 0 1 2 3 N/A

3. How long does it take you to **fall asleep**? _____ min _____ hours

4. How many **times do you wake** at night? _______________________________________________________

5. Is **waking up frequently** at night a problem? 0 1 2 3 N/A

6. Do you **awaken early** and have trouble getting back to sleep? 0 1 2 3 N/A
NOTE:  0 = Never  1 = Rarely  2 = Sometimes  3 = Frequently  N/A = not applicable

1. Do you **snore** at night?  
   Is it worse sleeping on your back?  □ Yes □ No □ Don’t know  
   Check here if you don’t know whether or not you snore □  
   0  1  2  3  N/A

2. Is your snoring **loud**?  
   0  1  2  3  N/A

3. Does your **snoring** bother other people?  
   0  1  2  3  N/A

4. Have you ever been told that you **stop breathing during sleep**?  
   0  1  2  3  N/A

5. Do you ever wake up from sleep **gasp**ing for **air**?  
   0  1  2  3  N/A

6. Do you get the **irresistible urge to sleep** despite wanting very much to stay awake?  
   0  1  2  3  N/A

7. Have you had any accidents or near-accidents while driving due to sleepiness?  
   0  1  2  3  N/A

8. Do you have **daytime fatigue** or decreased **energy**?  
   0  1  2  3  N/A

9. Are you still **tired/unrefreshed** when you awaken in the morning?  
   0  1  2  3  N/A

10. Do you have **headaches** upon awakening in the morning?  
    0  1  2  3  N/A

11. Do you **urinate frequently** at night?  
    0  1  2  3  N/A

12. Do you have **heartburn** or chest pain (“hot burps”) during sleep?  
    0  1  2  3  N/A

13. Do you have **nasal congestion**?  
    0  1  2  3  N/A

14. Do you **breathe through your mouth** when you sleep?  
    0  1  2  3  N/A

15. Do you ever wake up with a **dry mouth**?  
    0  1  2  3  N/A

16. Do you **sleep on your back**?  
    0  1  2  3  N/A

17. Do you have **nightmares**?  
    0  1  2  3  N/A

18. Do you have **leg jerks** during sleep?  
    0  1  2  3  N/A

19. Do you have an **urge to move your legs** due to abnormal feelings of restlessness, discomfort or sensations?  
    0  1  2  3  N/A

20. Is the urge to move your legs **worse with rest**?  
    0  1  2  3  N/A

21. Does the urge to move your legs temporarily **improve with activity**?  
    0  1  2  3  N/A

22. Does the urge to move your legs increase in the evening or night?  
    0  1  2  3  N/A
23. Have you ever had **sudden weakness when excited**, surprised or laughing? (ie. Knee buckling, jaw dropping, falling to the ground) 0 1 2 3 N/A

24. Have you ever **felt paralyzed** (momentary inability to move) when waking up or falling asleep? 0 1 2 3 N/A

25. Have you ever had **vivid lifelike images** or hallucinations as you fall asleep or wake up? 0 1 2 3 N/A

26. Do you **dream during short naps**? 0 1 2 3 N/A

27. Do you **grind your teeth** at night? 0 1 2 3 N/A

28. Do you **eat in your sleep** without realizing it? (ie. find empty food cartons, crumbs on awakening) 0 1 2 3 N/A

29. Do you **act out your dreams** in your sleep? (ie. Yell, punch, kick or other movements in the setting of dreams) 0 1 2 3 N/A

30. Do you have a history of **sleepwalking**? _____ No ___ Yes

30. Has your **weight changed** recently? ☐ Yes ☐ No  How much? _____________________

Weight gain ☐  Weight loss ☐

**Sleep Studies and CPAP Use (if applicable):**

Have you ever had a sleep study? Where? When?
__________________________________________________________________________________

Have you ever been diagnosed with sleep apnea or another sleep disorder? What?
__________________________________________________________________________________

Are you currently using CPAP/BiPAP? ☐ Yes ☐ No What pressure? ____________________________

How often do you currently use CPAP? ___________ days/week ___________ hours/night

If you are not using it now, did you use CPAP/BIPAP in the past? ☐ Yes ☐ No When? ___________

Did you have trouble tolerating CPAP/BIPAP? ☐ Yes ☐ No Why? ______________________________

If you are not using PAP now, for how long did you try/use PAP? ___________ days/months/years (circle) ___________ hours/night

What type of mask did you/ do you use? Full face  Nasal Pillows  Nasal  Other ________________

Who is your home care company?
Baystate Home Infusions  North Atlantic Medical  Apria  Flynn’s  Lincare  J&L
Medical History:
Do you have any of the following?

- [ ] Coronary artery disease
- [ ] Myocardial infarction (heart attack)
- [ ] Congestive heart failure, EF if known ______
- [ ] Atrial fibrillation
- [ ] Stroke/TIA
- [ ] Hypothyroidism
- [ ] Diabetes Mellitus
- [ ] High blood pressure
- [ ] Obesity
- [ ] High cholesterol
- [ ] Asthma
- [ ] COPD (emphysema/chronic bronchitis)
- [ ] Pulmonary Hypertension
- [ ] Gastric reflux (heartburn)
- [ ] Seasonal allergies
- [ ] Depression
- [ ] Bipolar
- [ ] Seasonal affective disorder
- [ ] Anxiety
- [ ] Fibromyalgia
- [ ] Chronic fatigue syndrome
- [ ] ADHD
- [ ] Migraines
- [ ] Seizures/Epilepsy
- [ ] Neuromuscular disorder
- [ ] Parkinson’s Disease
- [ ] Restless legs syndrome
- [ ] Broken nose/face
- [ ] Dental problems
- [ ] Sinus problems
- [ ] Deviated nasal septum
- [ ] Surgery on the nose
- [ ] Tonsillectomy
- [ ] Adenoids removed
- [ ] Kidney disease
- [ ] Anemia
- [ ] Other: ______________________

Social History:
Do you share a bed with? (circle all that apply) Significant other Children Pets

Occupation: _____________________________________________________________

What is your work/school schedule? _______________________________________

Tobacco: Do you smoke or chew tobacco? [ ] Yes [ ] Never [ ] Quit

_____ # packs per day  _______ #years  If quit when _________________________

Alcohol: Assuming one glass of wine, one shot of liquor or one beer is one drink, how many alcoholic beverages do you typically drink each day on weekdays? ______
on weekends? _________

Does alcohol alter or interfere with your sleep? [ ] Yes [ ] No

Caffeine: How many caffeinated beverages (coffee, tea, soda) do you consume daily?

_____ 8 oz servings. What do you consume (ie. 8 oz coffee, 1 can soda)?

Drugs: Do you currently use recreational drugs (ie. Marijuana, cocaine)? [ ] Yes [ ] No

If yes, describe ___________________________________________________________

Exercise: How many times a week do you exercise? ___________________________

What time of day do you usually exercise? _________________________________

Family History: Does anyone in your family have a sleep disorder? Who?

Sleep apnea  [ ] Yes [ ] No

Snoring  [ ] Yes [ ] No

Insomnia  [ ] Yes [ ] No

Narcolepsy  [ ] Yes [ ] No

Night terrors  [ ] Yes [ ] No

Restless leg syndrome  [ ] Yes [ ] No

Sleep walking  [ ] Yes [ ] No
List any medications you take on a daily basis including tranquilizers, stimulants, sleeping pills and herbal medications: *If you brought a list with you, we can copy it.* (Please continue on other side if needed)

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSE/ HOW MANY TIMES A DAY</th>
<th>PURPOSE OF MEDICATIONS</th>
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<tbody>
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Please list your drug allergies: ____________________________________________________

Have you ever taken stimulants (Provigil, Nuvigil, Ritalin, Amphetamines)? □ Yes □ No
If yes, what and when?
_____________________________________________________________________

What sleep medications including herbal and over the counter have you tried in the past?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
### Review of Systems:

Please indicate if you have had these symptoms in the last month

<table>
<thead>
<tr>
<th>General</th>
<th>Respiratory</th>
<th>Genitourinary</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Good general health</td>
<td>□ Shortness of breath</td>
<td>□ Unable to hold urine</td>
</tr>
<tr>
<td>□ Night sweats</td>
<td>□ Wheezing</td>
<td>□ Pain or burning on urination</td>
</tr>
<tr>
<td>□ Fevers</td>
<td>□ Chronic or frequent cough</td>
<td>□ Excessive urination</td>
</tr>
<tr>
<td>□ Fatigue</td>
<td>□ Spitting up blood</td>
<td>□ Blood in urine</td>
</tr>
<tr>
<td>□ Eye disease or injury</td>
<td>□ Loss of appetite</td>
<td>□ Pain or lump in testis</td>
</tr>
<tr>
<td>□ Blurry vision</td>
<td>□ Difficulty swallowing</td>
<td>□ Sexual difficulty</td>
</tr>
<tr>
<td>□ Double vision</td>
<td>□ Heartburn</td>
<td>□ Pain with intercourse</td>
</tr>
<tr>
<td>□ Eye pain</td>
<td>□ Abdominal pain</td>
<td>□ Irregular periods</td>
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<tr>
<td>□ Loss of hearing</td>
<td>□ Nausea</td>
<td>□ Pain or lump in breasts</td>
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<tr>
<td>□ Nasal Obstruction</td>
<td>□ Vomiting</td>
<td>□ Kidney stones</td>
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<tr>
<td>□ Sore gums or tongue</td>
<td>□ Change in bowel movements</td>
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<tr>
<td>□ Dental problems</td>
<td>□ Constipation</td>
<td></td>
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<tr>
<td>□ Jaw pain</td>
<td>□ Diarrhea</td>
<td></td>
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<tr>
<td>□ Hoarseness</td>
<td>□ Rectal bleeding</td>
<td></td>
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<tr>
<td>□ Neck stiffness or pain</td>
<td>□ Muscle cramps</td>
<td></td>
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<tr>
<td>□ Mouth sores</td>
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<tr>
<td>□ Nose bleeds</td>
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<tr>
<td>□ Swollen glands in the neck</td>
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</tbody>
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<thead>
<tr>
<th>Ear, Nose, Throat</th>
<th>Gastrointestinal</th>
<th>Skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Loss of hearing</td>
<td>□ Loss of appetite</td>
<td>□ Rash</td>
</tr>
<tr>
<td>□ Ringing in the ears</td>
<td>□ Difficulty swallowing</td>
<td>□ Dry skin</td>
</tr>
<tr>
<td>□ Nasal Obstruction</td>
<td>□ Heartburn</td>
<td>□ Hives or itching</td>
</tr>
<tr>
<td>□ Sore gums or tongue</td>
<td>□ Abdominal pain</td>
<td>□ Change in hair or nails</td>
</tr>
<tr>
<td>□ Dental problems</td>
<td>□ Nausea</td>
<td>□ New or changed dark spot</td>
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<tr>
<td>□ Jaw pain</td>
<td>□ Vomiting</td>
<td>□ Change in skin color</td>
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<td>□ Hoarseness</td>
<td>□ Change in bowel movements</td>
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<tr>
<th>Cardiovascular</th>
<th>Muscle/ Skeletal</th>
<th>Nervous / Mental</th>
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<tbody>
<tr>
<td>□ Chest pain</td>
<td>□ Back pain</td>
<td>□ Headaches</td>
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<tr>
<td>□ Palpitations</td>
<td>□ Neck pain</td>
<td>□ Dizziness</td>
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<tr>
<td>□ Irregular heart beat</td>
<td>□ Joint pain</td>
<td>□ Loss of balance</td>
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<tr>
<td>□ Swollen feet or legs</td>
<td>□ Joint swelling</td>
<td>□ Fainting</td>
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<tr>
<td>□ Lower leg pain when walking</td>
<td>□ Muscle cramps</td>
<td>□ Light headed</td>
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<tr>
<td>□ Shortness of breath lying flat</td>
<td></td>
<td>□ Memory loss</td>
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<td></td>
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<td>□ Numbness</td>
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<td>□ Muscle weakness</td>
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<td>□ Tremors</td>
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<td>□ Paralysis</td>
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<td></td>
<td>□ Head injury</td>
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<td>□ Depression</td>
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<td>□ Anxiety</td>
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<td>□ Stress</td>
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<td></td>
<td>□ Confusion</td>
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<table>
<thead>
<tr>
<th>Endocrine</th>
<th>Hematologic</th>
<th>Revised 6/30/2015</th>
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<tbody>
<tr>
<td>□ Excessive thirst</td>
<td>□ Lymph node pain or swelling</td>
<td></td>
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<tr>
<td>□ Intolerance to heat</td>
<td>□ Easy bleeding or bruising</td>
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<tr>
<td>□ Intolerance to cold</td>
<td>□ Anemia</td>
<td></td>
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<tr>
<td>□ Hot flashes</td>
<td>□ Leg clots</td>
<td></td>
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<tr>
<td>□ Glandular or hormone problem</td>
<td>□ Past transfusion</td>
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<td>□ Dry skin</td>
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<tr>
<td>□ Change in hat or glove size</td>
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Revised 6/30/2015