New Patient Questionnaire- Sleep Disorders Center

Date______________________

Name____
(first) (middle) (last)

Address:____
(street) (city/town) (state) (zip)

Contact Information:

Home phone:_____________ Cell phone:_______________

E-mail:____ Preferred method of contact_______________

Date of Birth________________ Age__________ Height______________ Weight_____________

Neck size__________ Marital Status_____________

Referring Physician____________________________ Primary Care Provider___________________________

Have you seen any other physician for your sleep problem? □ No □ Yes (please provide information)

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____
____

Sleep Issue Questions:

How would you describe your sleep problem? *Check all that apply.*
□ Snoring □ Difficulty falling asleep □ Daytime sleepiness □ Difficulty awakening
□ Waking up during the night

How many nights per week do you have a sleeping problem? ____________________________

How long have you had this problem?____

Please estimate the severity of your problem.

□ Mild □ Moderate □ Extreme

Please describe your sleep problem, including when and how it began

____
____
____

Sleep Habits

On average, how long do you sleep at night? ______________________________________
How long does it take you to fall asleep? ______________________________________
How many times do you wake up at night? (please describe)
____
____
____

	Yes	No
Is your bedroom quiet and dark?		
Is your sleep disturbed by your bed partner?		
Do you sleep with pets?		
Do your children sleep in your bed?		
Do you worry excessively in bed?		
Do you drink caffeine within 2 hours of bedtime?		
Do you do physical activity before bed?		
Do you read before falling asleep?		
Do you watch TV in bed before falling asleep?		
Do you sleep better in your easy chair than in your bed?		
Do you work variable or rotating shifts?		
Do you feel excessively sleepy while driving?		
Have you ever fallen asleep while driving or when stopped?		
Do you fall asleep easily while riding as a passenger?		
Have you fallen asleep in a public place?		
Do you nap during the day? If so, how many and how long?		
Do you feel refreshed after a short nap?		
Have you been told you talk in your sleep?		
Have you been told you walk in your sleep?		
Have you been told of any abnormal behaviors during sleep? (describe)		
Have you ever awakened with your whole body paralyzed? (explain)		
Do you hear or see things in the beginning or end of your sleep that are not real?		
Have you ever had an episode of severe muscle weakness associated with laughter, anger or increased activity? (describe)		
Have you ever had sudden attacks of sleeping? (describe)		
Do you have restless or uncomfortable feelings in your legs?		
• Are these worse at night?		
• Are they relieved with movement?		
• Cramping in your legs at night?		
Do you have headaches in the morning?		
Do you have jaw pain in the morning?		
Do you grind your teeth at night?		
Have you awakened short of breath or gasping for air?		
Have you awakened at night with heartburn, belching or cough?		
Have you had increased irritability or trouble thinking?		
Has daytime sleepiness affected your job or school performance?		

SNORING AND SLEEP APNEA	PLEASE DESCRIBE:
Do you snore?	
• How often do you snore?	
• How many years have you been snoring?	
• How severe is your snoring?	
• Has your snoring become progressively worse?	
• Have you ever awakened because of your snoring?	
Have you been observed to stop breathing when you sleep?	
In what positions do you snore? *(please check all that apply)*	□*Back* □*Side* □*Stomach* □*Sitting*
Which best describes your pattern of snoring?	□ snoring is present continuously
	□ snoring is present occasionally
	□ I snore, stop breathing then snore again

REVIEW OF SYSTEMS

Cardiac:

Do you have chest pain or pressure?
□Yes □No
Do you have palpitations or a racing heart?
□Yes □No
Do you have ankle or feet swelling?
□Yes □No
Do you have high blood pressure?
□Yes □No
Other: ________________________

Pulmonary:

Shortness of breath?
□Yes □No
Chronic cough?
□Yes □No
Asthma?
□Yes □No
COPD?
□Yes □No
Other: ________________________

Gastrointestinal:

Do you have heartburn?
□Yes □No
Difficulty with your bowels?
□Yes □No

Explain:________________________
____
____

ENT:

Headaches? □Yes □No
Nasal stuffiness or discharge?
□Yes □No
Sinus issues? □Yes □No
Sore Throat? □Yes □No
Ear Pain? □Yes □No
Do you have dentures?
□Yes □No
Have you had your tonsils removed? □Yes □No

Other: ________________________

Genitourinary:

Difficulty passing urine?
□Yes □No
Do you wake up to urinate?
□Yes □No
Times per night? ________
Are currently going through menopause?
□Yes □No
Have difficulty with erections?
□Yes □No

Explain: ________________________
____

Musculoskeletal:

Do you have chronic pain?
□Yes □No
Does your pain interfere with sleep?
□Yes □No
Do you awake with numbness in your limbs?
□Yes □No
Other: ________________________
____

Neurological:

Do you have numbness or tingling?
□Yes □No __________________
Dizziness or balance issues?
□Yes □No
Blurry vision or recent black outs?
□Yes □No
Do you awaken from sleep feeling paralyzed?
□Yes □No
History of stroke?
□Yes □No
History of Migraines?
□Yes □No

Psychosocial:

Do you feel Depressed or anxious?
□Yes □No
Are you more irritable than in the past? □Yes □No
Do you smoke?
□Yes □No How many__________
Do you drink alcohol?
□Yes □No How many _________
Do you use recreational drugs?
□Yes □No
Do you smoke marijuana?
□Yes □No

Other Health Conditions:

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____
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____
____
____
____
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____
____

Please complete the following medication list or you may attach a copy of your own list:
(Please include all over the counter medications and supplements)

MEDICATION NAME	DOSAGE	FREQUENCY	REASON TAKEN

Please complete the following allergy list, including reaction or you may attach a copy of your own list:

ALLERGY	REACTION

SURGICAL PROCEDURES:

Type of Surgery	Date	Place

Additional Comments:

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