

**SLEEP DISORDERS CENTER  
SLEEP CLINIC PATIENT QUESTIONNAIRE**

Please bring this completed questionnaire with you to your sleep clinic appointment.

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Clinic Location: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Clinic Location: \_\_\_\_\_

1. Why are you being seen in the sleep clinic? \_\_\_\_\_
2. Have you been evaluated in a sleep clinic previously?  YES  NO
3. If so, please list clinic, dates, and diagnoses: \_\_\_\_\_
4. List dates and locations of prior polysomnograms (*Sleep Studies*): \_\_\_\_\_

*If you previously had polysomnograms (Sleep Studies), please bring them with you to your appointment.  
Contact the Sleep Disorders Office if you need assistance obtaining the studies.*

5. Have you previously been diagnosed with sleep apnea?  YES  NO
  - a) If so, have you been treated with CPAP?  YES  NO
  - b) Pressure settings, if known: \_\_\_\_\_
6. Have you had surgery for either snoring or sleep apnea?  YES  NO
  - a) If yes, list type/dates/location: \_\_\_\_\_

**I. TYPICAL SLEEP HABITS**

1. What time do you typically go to bed on weekdays? \_\_\_\_:\_\_\_\_ am/pm
2. How long does it take you to fall asleep? \_\_\_\_\_(hours/min)
3. What time do you typically awaken on weekdays? \_\_\_\_:\_\_\_\_ am/pm
  - a. Do you use an alarm clock/wake up call?  YES  NO
  - b. Do you feel refreshed upon awakening?  YES  NO
4. What time do you typically go to bed on the weekend/days off? \_\_\_\_:\_\_\_\_ am/pm
5. How long does it take you to fall asleep? \_\_\_\_\_(hours/min)
6. What time do you awaken on the weekend/days off? \_\_\_\_:\_\_\_\_ am/pm
  - a. Do you use an alarm clock/wake up call?  YES  NO
  - b. Do you feel refreshed upon awakening?  YES  NO
7. How many times do you awaken on a typical night? \_\_\_\_\_
8. Do you have difficulty returning back to sleep?  YES  NO
9. Check typical causes for awakening at night:

<input type="checkbox"/> Snoring	<input type="checkbox"/> Pain	<input type="checkbox"/> Full bladder	<input type="checkbox"/> Noise
<input type="checkbox"/> Nightmares	<input type="checkbox"/> Worry	<input type="checkbox"/> Thirst/hunger	<input type="checkbox"/> Bed partner/kids/pets
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Headache	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Choking/gasping

Please list other causes: \_\_\_\_\_

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10. Do you nap intentionally?  YES  NO
- a) If yes, how many days per week? \_\_\_\_\_
- b) What time of day? \_\_\_\_\_
- c) How long are naps? \_\_\_\_\_
- d) Do you feel refreshed upon awakening from the nap?  YES  NO

### How often do you or others notice the following?

(Please Circle):

	Almost never	Rarely (once a month)	Some (once a week)	Often (2-4 times a week)	Almost Always	
1. Snoring	0	1	2	3	4	
2. Breathing pauses when you sleep	0	1	2	3	4	
3. Wake up choking or gasping from sleep	0	1	2	3	4	
4. Wake up with shortness of breath	0	1	2	3	4	
5. Wake up with dry mouth	0	1	2	3	4	
6. Wake up with sore throat	0	1	2	3	4	
7. Nasal/sinus congestion	0	1	2	3	4	
8. Morning headaches	0	1	2	3	4	
9. Wake to urinate 2 or more times per night	0	1	2	3	4	
10. Heartburn interfering with sleep	0	1	2	3	4	
11. Problems with fainting?	0	1	2	3	4	
12. Light headed when standing?	0	1	2	3	4	
13. Cold extremities?	0	1	2	3	4	
14. Grind teeth while sleeping	0	1	2	3	4	
15. Nightmares	0	1	2	3	4	
16. Sleep walking	0	1	2	3	4	
17. Sleep talking	0	1	2	3	4	
18. Acting out dreams	0	1	2	3	4	
19. Restlessness or discomfort in the legs	0	1	2	3	4	
If yes, is this worse at night? <input type="checkbox"/> Y <input type="checkbox"/> N						
If yes, is this relieved by movement? <input type="checkbox"/> Y <input type="checkbox"/> N						
20. Kicking/jerking of legs while sleeping	0	1	2	3	4	
21. Hallucinations when falling asleep or upon awakening	0	1	2	3	4	
22. Momentary complete paralysis when falling asleep or upon awakening	0	1	2	3	4	
23. <b>While awake</b> , do you have episodes of muscle weakness brought on by strong emotion	0	1	2	3	4	
	None				"Earth Shattering"	
24. How would you rank the intensity of your snoring on a scale of 0 to 5?	0	1	2	3	4	5

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This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to circle the most appropriate response for each situation.

**How likely are you to doze off or fall asleep (not just feel tired) in the following situations?**

*(Please Circle)*

	No chance	Slight chance	Moderate chance	High chance
1. Sitting and reading	0	1	2	3
2. Watching TV	0	1	2	3
3. Sitting inactive in a public place <i>(like a theater or a meeting)</i>	0	1	2	3
4. Riding as a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon when circumstances permit	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after lunch without alcohol	0	1	2	3
8. In a car, while stopped for a few minutes in traffic	0	1	2	3
9. At the dinner table	0	1	2	3
10. While driving	0	1	2	3

**How often do you experience each of the following?**

*(Please Circle)*

	Almost Never	Rarely <i>(once a month)</i>	Some <i>(once a week)</i>	Often <i>(2-4 times a week)</i>	Almost Always
1. I have trouble falling asleep	0	1	2	3	4
2. I wake up during the night and have difficulty getting back to sleep	0	1	2	3	4
3. I have frequent awakenings at night but <b>no</b> difficulty returning to sleep	0	1	2	3	4
4. I wake up too early in the morning and am unable to get back to sleep	0	1	2	3	4
5. I have difficulty waking in the morning	0	1	2	3	4
6. I do not get enough sleep	0	1	2	3	4
7. I am sleepy during the day	0	1	2	3	4
8. Daytime fatigue is a problem for me	0	1	2	3	4

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### II. REVIEW OF SYSTEMS *Check all boxes that apply to you:*

<b>NEUROLOGICAL</b> <input type="checkbox"/> Headaches <input type="checkbox"/> Dizzy spells <input type="checkbox"/> Seizures <input type="checkbox"/> Fainting <input type="checkbox"/> Memory loss <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Weakness	<b>GASTROINTESTINAL</b> <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody or black stools <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Heartburn <input type="checkbox"/> Vomiting blood	<b>EAR/NOSE/THROAT</b> <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ear aches <input type="checkbox"/> Sinus pain <input type="checkbox"/> TMJ pain or clicking <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Nasal drainage <input type="checkbox"/> Nasal polyps <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Mouth sores <input type="checkbox"/> Hoarseness
<b>HEART</b> <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Swelling of feet	<b>MUSCULOSKELETAL/SKIN</b> <input type="checkbox"/> Joint pain/swelling <input type="checkbox"/> Muscle pain <input type="checkbox"/> Back pain <input type="checkbox"/> Neck pain <input type="checkbox"/> Rash	<b>EYES</b> <input type="checkbox"/> Visual changes <input type="checkbox"/> Eye pain
<b>LUNG</b> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Coughing <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Wheezing	<b>ALLERGY/IMMUNOLOGY</b> <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Eczema	<b>ENDOCRINE</b> <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Heat/cold intolerance <input type="checkbox"/> Hot flashes
<b>KIDNEY/BLADDER</b> <input type="checkbox"/> Urinate frequently <input type="checkbox"/> Painful urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Sexual difficulty	<b>GENERAL</b> <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Unexpected weight loss <input type="checkbox"/> Weight gain	<b>BLOOD</b> <input type="checkbox"/> Anemia <input type="checkbox"/> Easy bruising/bleeding
		<b>PSYCHIATRIC</b> <input type="checkbox"/> Anxiety/nervousness <input type="checkbox"/> Depression/ sadness <input type="checkbox"/> Irritability / moodiness

### III. ALLERGIES

List all previous reactions to medications:

Medication	Reaction
1.	
2.	
3.	
4.	
5.	
6.	
7.	

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### IV. MEDICATIONS

List medications you currently take (please include "over the counter", vitamins, and herbal remedies):

	Medication	Dose	Times Per Day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Have you taken any medications (prescription/over the counter) to help you sleep?  YES  NO

If **yes**, please list medication, dates taken and effectiveness:

Medication	Date taken	Effectiveness

### V. PAST MEDICAL HISTORY

1. In general, would you say your health is: (Please check)

Excellent     Very Good     Good     Fair     Poor

2. What is your current weight? \_\_\_\_\_ Height? \_\_\_\_\_ Collar size (men)? \_\_\_\_\_  
 Weight one year ago? \_\_\_\_\_ At age 20? \_\_\_\_\_

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3. Have you had any of the following medical conditions? (Check appropriate boxes)

<b>HEART DISEASE</b> <input type="checkbox"/> Heart failure <input type="checkbox"/> Heart attack <input type="checkbox"/> Angina <input type="checkbox"/> Atrial fibrillation <input type="checkbox"/> Arrhythmia <input type="checkbox"/> High blood pressure	<b>GASTROINTESTINAL</b> <input type="checkbox"/> Liver disease <input type="checkbox"/> Stomach ulcers <input type="checkbox"/> Reflux disease <input type="checkbox"/> Colitis	<b>NEUROLOGY</b> <input type="checkbox"/> Stroke or TIA's <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Seizure <input type="checkbox"/> Spinal cord injury <input type="checkbox"/> Head injury
<b>LUNG DISEASE</b> <input type="checkbox"/> COPD/Emphysema <input type="checkbox"/> Chronic bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia	<b>KIDNEY / BLADDER</b> <input type="checkbox"/> Kidney failure <input type="checkbox"/> Enlarged prostate	<b>ENDOCRINE</b> <input type="checkbox"/> Diabetes: <input type="checkbox"/> Thyroid disease
<b>MUSCULOSKELETAL</b> <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Spine/back surgery	<b>EAR/NOSE / THROAT</b> <input type="checkbox"/> Chronic sinusitis <input type="checkbox"/> Seasonal allergy <input type="checkbox"/> Nasal surgery <input type="checkbox"/> Tonsillectomy	<b>MISCELLANEOUS</b> <input type="checkbox"/> Cancer Type: _____ Metastatic? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Peripheral vascular disease <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Anemia <input type="checkbox"/> Blood clots <input type="checkbox"/> Major trauma _____ <input type="checkbox"/> Chronic fatigue syndrome <input type="checkbox"/> Leukemia or lymphoma
	<b>PSYCHIATRIC</b> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Dementia <input type="checkbox"/> Alcoholism	

1. Please describe (with date and location) any prior nasal, oral, throat, jaw, head or neck surgeries: \_\_\_\_\_

2. Please list any past surgeries or illnesses not mentioned above: \_\_\_\_\_

### VI. SOCIAL HISTORY

**Marriage Status:**

- Single
- Married
- Widowed
- Divorced
- Domestic partner

**Children:**

- None
  - Yes, but not living with me
  - Yes, living with me
- Ages: \_\_\_\_\_

**Work Status:**

- Full time employment
- Part time employment
- Retired
- Unemployed
- Self-employed
- Disabled
- Student

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1. Occupation (*Brief description*): \_\_\_\_\_
2. Does your partner sleep in the same room?     YES     NO     DOES NOT APPLY
3. How often do you drink alcoholic beverages?
 

<input type="checkbox"/> Never	<input type="checkbox"/> Less than one drink a day
<input type="checkbox"/> Less than once a month	<input type="checkbox"/> 1-2 drinks a day
<input type="checkbox"/> Less than once a week	<input type="checkbox"/> More than 2 drinks a day
4. Tobacco Use:
 

<input type="checkbox"/> Never	
<input type="checkbox"/> Current Smoker: # Years of smoking: _____	Average # packs/day: _____
<input type="checkbox"/> Never	
<input type="checkbox"/> Former Smoker: Quit date: _____	Approx # of years smoked: _____
Average # packs/day: _____	
5. Please list any past or current recreational drug use (*marijuana, cocaine, etc.*):  
\_\_\_\_\_
6. How many caffeine-containing beverages do you consume on a typical day?  
a. Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Coca-Cola/Mountain Dew \_\_\_\_\_
7. What time would you typically consume your last caffeinated drink?    \_\_\_\_:\_\_\_\_ am/pm

### VII. FAMILY HISTORY

1. Does anyone in your immediate family (parents, sibling or children) have the following medical conditions?  
*Please indicate F for father, M for mother, S for sibling and C for child. Circle all that apply*

<b>SLEEP DISORDER</b> <input type="checkbox"/> Sleep apnea <b>F, M, S, C</b> <input type="checkbox"/> Snoring <b>F, M, S, C</b> <input type="checkbox"/> Narcolepsy <b>F, M, S, C</b> <input type="checkbox"/> Restless legs syndrome <b>F, M, S, C</b>	<b>CANCER</b> <input type="checkbox"/> Breast cancer <b>F, M, S, C</b> <input type="checkbox"/> Colon cancer <b>F, M, S, C</b> <input type="checkbox"/> Prostate cancer <b>F, M, S, C</b> <input type="checkbox"/> Other: <b>F, M, S, C</b>	<b>PSYCHIATRIC</b> <input type="checkbox"/> Anxiety/depression <b>F, M, S, C</b> <input type="checkbox"/> Alcoholism <b>F, M, S, C</b>
<b>ENDOCRINE</b> <input type="checkbox"/> Diabetes <b>F, M, S, C</b> <input type="checkbox"/> Thyroid disease <b>F, M, S, C</b>	<b>HEART DISEASE</b> <input type="checkbox"/> Arrhythmia <b>F, M, S, C</b> <input type="checkbox"/> Heart attack/angina <b>F, M, S, C</b> <input type="checkbox"/> High cholesterol <b>F, M, S, C</b> <input type="checkbox"/> High blood pressure <b>F, M, S, C</b> <input type="checkbox"/> Heart failure <b>F, M, S, C</b>	<b>NEUROLOGY</b> <input type="checkbox"/> Parkinson's Disease <b>F, M, S, C</b> <input type="checkbox"/> Stroke <b>F, M, S, C</b> <input type="checkbox"/> Seizure <b>F, M, S, C</b>
<b>LUNG DISEASE</b> <input type="checkbox"/> Emphysema <b>F, M, S, C</b> <input type="checkbox"/> Asthma <b>F, M, S, C</b>		<b>OTHER</b> <input type="checkbox"/> Liver disease <b>F, M, S, C</b> <input type="checkbox"/> Kidney failure <b>F, M, S, C</b> <input type="checkbox"/> Blood clots <b>F, M, S, C</b>

2. Other conditions not listed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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### VIII. INSOMNIA

1. Do you have problems getting to sleep or staying asleep?  YES  NO

a. If no, you may stop here.

b. If yes, please continue answering the following questions:

2. Please rate the current, (*i.e. the last 2 weeks*) SEVERITY of your insomnia problem(s):

	None	Mild	Moderate	Severe	Very
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problem waking up too early	0	1	2	3	4

	Very Satisfied				Very Dissatisfied
1. How SATISFIED or DISSATISFIED are you with your current sleeping pattern?	0	1	2	3	4
	Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
2. To what extent do you consider your sleep problem to INTERFERE with your daily functioning? ( <i>i.e., daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.</i> )	0	1	2	3	4
	Not at all Noticeable	Barely	Somewhat	Much	Very Noticeable
3. How NOTICEABLE to others do you think your sleeping problem is in terms of impairing the quality of your life?	0	1	2	3	4
	Not at all	A Little	Somewhat	Much	Very Much
4. How WORRIED or DISTRESSED are you about your current sleep problem?	0	1	2	3	4

Thank you for taking the time to complete this questionnaire.

Patient Signature	Print Name	Date
Reviewers Signature	Print Name	Date

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