

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Dr: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Family Dr: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vitals: (For Nurse’s Use Only)**

## Weight:\_\_\_\_\_\_\_\_\_\_\_Height\_\_\_\_\_\_\_\_BP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pulse:\_\_\_\_\_\_\_\_\_\_\_Oximetry:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##

## Neck Circumference:\_\_\_\_\_\_\_\_BMI:\_\_\_\_\_\_\_ESS:\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please help us find out about you by filling out the **left** side of this form. Please leave the right side blank.

**Have you been evaluated in a sleep clinic previously? YES NO**

**Have you had a sleep study? YES NO**

**If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What was your diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(If you previously had a Sleep Study, please bring them with you to your**

**appointment.)**

**Have you had surgery for either snoring or sleep apnea? YES NO**

 **If yes, list type, date and location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you currently us a CPAP machine? YES NO**

**If yes, do you have a data card? YES NO**

**If yes, please bring your data/SD card with you to your appointment.**

**Why are you here to see a sleep specialist? CC:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Do you snore? HPI:**

* Yes
* No
* Don’t know

How long ago did it start?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Is it worsening? **Yes No**

In which position do you snore?

* Back only
* All positions

Do you snore if you fall asleep in a chair? **Yes No**

Has anyone ever noticed if you stop breathing while sleeping?

* Yes
* No

**Do you suffer from either of the following in the morning?**

* Dry mouth
* Headache

**Do you feel sleepy during the daytime?**

* Yes
* No
* Don’t know

How many days per week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did it start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it worsening? Yes No

**Do you ever dream while you are falling asleep or during naps?**

* **Yes**
* **No**

**Do you walk or talk in your sleep? Yes No**

**Do you ever accidentally urinate in bed? Yes No**

**Do you have nightmares? Yes No**

**Do you feel sleepy watching TV?**  **Yes No**

**Do you feel sleepy reading?** **Yes No**

**Have you ever had a close call or accident when driving because**

**of sleepiness? Yes No**

**Do you suffer from memory problems? Yes No**

**Are you more irritable lately? Yes No**

**Do you take any daytime naps? Yes No**

How many per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How long on average do they last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#  Are the naps refreshing? Yes No

**How likely are you to doze off or fall asleep doing the following:**

Use the following scale:

1. Would never doze
2. Slight chance of dozing
3. Moderate chance of dozing
4. High chance of dozing

\_\_\_\_\_ Sitting and reading

\_\_\_\_\_ Watching television

\_\_\_\_\_ Sitting inactive in a public place

\_\_\_\_\_ While a passenger in a car without a break

\_\_\_\_\_ Laying down to rest in the afternoon when circumstances

 permit

\_\_\_\_\_ Sitting and talking to someone

\_\_\_\_\_ Sitting quietly after a lunch without alcohol

\_\_\_\_\_ In a car, while stopped in traffic for a few minutes Epworth score: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Rate the severity of your sleepiness on a scale of 1 to 10 (1 being** BMI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**No sleepiness and 10 being very severe sleepiness) \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you ever experience restlessness or discomfort in your legs?**

* Yes
* No

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you do to relieve it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does it occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it interfere with sleep? Yes No

Do you move or kick your legs while sleeping? Yes No

**Have you ever felt the sudden loss of strength (arms, legs) in response**

**to some emotional experience? Yes No**

**Have you ever felt paralyzed when you first wake up or when you are**

**falling asleep? Yes No**

**Tell us about your sleep schedule.**

What is your bedtime? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What time do you get up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long does it take you to fall asleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wake up in the middle of the night? Yes No

 How many times? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you fall asleep again easily? Yes No

**Do you use any over the counter or prescribed meds to help sleep?**

 **Yes No** **To keep you awake? Yes No**

**Please list any illnesses you are currently being treated for: Past Medical History:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Check off any lung or breathing problems:**

* Shortness of breath
* Unable to catch your breath
* Wheezing
* Chest pains or pressure
* Coughing up phlegm or blood
* Sudden onset of difficulty breathing
* Unable to sleep lying flat or with one pillow
* Night sweats
* Swollen legs
* Blue lips or fingernails
* Leg cramps when you walk
* Seasonal variation of symptoms
* Nonproductive cough

**Have you ever had:**

* Asthma
* Hay fever
* Pulmonary function or spirometry test
* Bronchoscopy or bronchial/lung biopsy
* Lung surgery, including complete or partial removal
* Heart surgery
* Lung cancer or any type of cancer
* Exposure to tuberculosis or had tuberculosis
* Positive skin test for TB
* Pneumonia
* Blood clot
* Cardiac Palpitations
* Atrial Fibrillation

**Have you ever had any operations or injuries? Past Surgical History:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Have you had a tonsillectomy or nasal surgery? (please circle)**

* **Yes**
* **No**

**Check if any close family member (parents, brothers, sisters, Family History:**

**children) has:**

* Heart problems
* Cardiac Palpitations
* Atrial Fibrillation
* High blood pressure
* Diabetes
* Lung cancer
* Any other cancer
* Heartburn
* Asthma
* Emphysema
* Tuberculosis
* Blood clots
* Miscarriages
* Sleep problems in family
* Other

**Are there any other health problems in your family:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status: Single Married Widowed Divorced Social History:**

**With whom do you live? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Do you smoke currently, or have you smoked in the past?

# Yes

#  No

**How many packs per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **For how many years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **If you quit, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you drink alcohol? Yes No**

If yes, what and how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you drink coffee, tea, soda or other caffeinated drinks? Yes No**

 If so, what and how much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you use any recreational drugs? Yes No**

**Have you had the following vaccinations, and when:**

* Flu Vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Pneumonia Vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list your medications (names, dosage, how many Medications:**

**times per day). Include over-the-counter meds:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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What pharmacy would you routinely use if a prescription needed to be

called in for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you allergic to any medications? Yes No Allergies:**

 **If yes, please list and include type of reaction.**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please circle any of the following symptoms you may have: Constitutional:**

 Lack of energy, daytime sleepiness, trouble sleeping,

snoring, loss of appetite, weight changes, fevers

Hearing problems, buzzing or ringing in ears **HEENT:**

Allergies, hay fever

Sinus problems

Blood pressure or heart problems  **Cardiac:**

Asthma, tuberculosis  **Pulmonary:**

Stomach problems, heartburn, indigestion, change in **Digestive:**

bowel habits

Bloody or tarry stools, jaundice, liver problems,

ulcers, gallstones

Urinary problems: frequency, infections, stones**, Urinary:**

night-time urination

Joint pains swelling or redness; arthritis back pain **Musculoskeletal:**

Muscle aches or tenderness, gout

Rash, itching or other skin problems  **Dermatological:**

Paralysis, stroke, numbness, loss of balance  **Neurological**

Seizures, loss of memory, headaches

Unusual thoughts, nervousness, crying or sadness  **Psychiatric:**

Depression, suicide attempts

Thyroid disorder, diabetes, excess thirst, hunger or  **Endocrinology:**

urination

Bleeding, easy bruising, risk factors for HIV, anemia,  **Hematological:**

Cancer

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dr. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Shared Documents/NP Questionnaire-Sleep