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ADULT NEW PATIENT QUESTIONNAIRE FOR AGE 18 AND OLDER

Part 1 – Patient Information

Name: ________________________ Social Security Number: ______________
Home Phone: ___________________ Work or Cell Phone: ________________
Date of Birth: ___________________ Today's Date: __________________
Height: _______ Weight: _______ Neck Circumference: _______ BMI: ________

Physicians caring for you (family doctor, specialists, psychologist, ext.) ___________
____

Part 2 - Main Complaint

What is your main sleep or alertness complaint? How long has it occurred?

____
____
____

If you have ever had a sleep study, please indicate when and where.

____
____

Part 3 - Day time Sleepiness

How would you rate your usual daily sleepiness?	None	Mild	Moderate	Severe
Do you fall asleep or become sleepy when:	Never	Sometimes	Often	Always
Driving?	1	2	3	4
At Work	1	2	3	4
Watching TV/Reading?	1	2	3	4
Sports/Church/Social Activities/School?	1	2	3	4
Do you take intentional naps?	1	2	3	4

What is the sleepiest time of the day?

____

If you are excessively sleepy or fatigued, how long has this been going on? Do you have any ideas as to why this is happening?

____

____

Part 4 – Sleep Routine

When do you go to bed on Weekdays? ______________ Weekends? ____________
What time to you get up on weekdays? _______________ Weekends? ____________
How long does it take to fall asleep? _______ Do you have trouble falling asleep? _____
How often do you awaken at night? _____________ What causes it? _____________
How long are you awake? __________ How often do you urinate at night? __________
How many hours of sleep do you get in a typical night? _________________________
Do you usually sleep alone? __________
How do you feel when you wake up? ____________________________________
Do your legs feel like you need to frequently move, rub or stretch them at night? _______

Part 5 – Sleep Events

While asleep do you:	Never	Sometimes	Often	Always
Snore?	1	2	3	4
Stop Breathing?	1	2	3	4
Gasp or choke?	1	2	3	4
Have heartburn or chest pain?	1	2	3	4
Toss and turn restlessly?	1	2	3	4
Grind your teeth?	1	2	3	4
Drool?	1	2	3	4
Have jerks or twitches?	1	2	3	4
Have nightmares?	1	2	3	4
Sleep in an unusual position?	1	2	3	4
Cough?	1	2	3	4
Wake up with headaches?	1	2	3	4
Wake up with a sore throat?	1	2	3	4
Wake up with a dry mouth?	1	2	3	4

Part 6 – Parasomnias

Do you sometimes awaken with the feeling you are completely paralyzed? __________
Do you ever hallucinate sights or sounds while falling asleep as if your dreams are beginning before you are fully asleep?____________________________________
Do you sleep walk, talk or moan? _____________________________________
Do you perform unusual behaviors during sleep? ______________________________

____

Do you have brief attacks of muscle weakness? _______________________________

____

Part 7 – Sleep Hygiene

Do you drink beverages with caffeine (coffee, tea, cola, Mountain Dew, etc.) or take caffeine pills? ____

If so, how much, what time of the day? ______________________________

Do you exercise routinely? If so, what time of the day? _________________

Do you do anything stressful or anxiety provoking before going to bed? If so, please describe:

____

____

Is there anything in your bedroom that could be disturbing your sleep? (Room temperature, noise, pets, etc.)

____

____

Do you nap more than once a week? ____________________________

Part 8 – Medications

Please list all medications, vitamins, herbal supplements and oxygen you currently take and the doses.

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Part 9 – Allergies

If none please state so, otherwise list them. Please include any metal allergies.

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Part 10 Operations

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____

____

Part 11 Illness and Injuries

____

____

____

Part 12 – Family History

Please list medical conditions in blood relatives (parents, siblings, and children) and who the relative is. Examples include high blood pressure, stroke, heart attack, diabetes, etc.

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Are there any sleep-related disorders in the family?

____

____

Part 13 – Review of Systems

Do you have problems relating to (please check all that apply):

- ☐ Breathing while awake
- ☐ Frequent headaches
- ☐ Heartburn
- ☐ Anxiety
- ☐ Depression
- ☐ Seizures
- ☐ Long term pain condition
- ☐ Loss of sex drive or performance
- ☐ Difficulty with concentration or memory
- ☐ Irritability or mood swings
- ☐ Weight gain or loss over the last few years
- ☐ Leg or ankle swelling
- ☐ Do you have dentures?

Part 14 – Social History

Occupation: ____________________ Who lives at home: ____________________

Marital Status: ____________________ Number of children: ____________________

Part 15 – Additional Information

Is there anything else that you feel may be important for the physician to know about your sleep and alertness problems or your health? ______________________________

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____

____

THE EPWORTH SLEEPINESS SCALE (ESS)

The ESS is a questionnaire designed to evaluate levels of excessive sleepiness. This test is a standardized screening tool used by the American association of Sleep Medicine that will help you measure your general level of sleepiness. It asks you to rate the chances that you would doze off or fall asleep during different routine situations. Answers to the questions are rated from 0 to 3, with 0 meaning you would never doze or all asleep in the given situation, and 3 meaning that there is a very high likelihood that you would doze or fall asleep in that situation.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION:	**CHANCE OF DOZING:**			
Sitting and reading	**0**	**1**	**2**	**3**
Watching TV	**0**	**1**	**2**	**3**
As a passenger in a car for an hour without a break	**0**	**1**	**2**	**3**
Lying down to rest in the afternoon	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**
Sitting quietly after lunch (without alcohol)	**0**	**1**	**2**	**3**
In a car, while stopped for a few minutes in traffic	**0**	**1**	**2**	**3**

Total score of less that 10 suggest that you may not be suffering from excessive sleepiness.

Total sore of 10 or more suggests that you may need further evaluation by a physician to determine the cause of your excessive sleepiness and whether you have an underlying sleep disorder. You should see your primary care provider or sleep specialist to discuss your options.

Bed Partner / Sleep Observer Questionnaire

Name of patient: ____

Your relationship to the patient: ______________________________________

How often have you observed this person's sleep?
☐ Never ☐ Once or twice ☐ Often ☐ Every night

The patient snores when sleeping on/in:
☐ The back only ☐ Sides too ☐ All positions ☐ Does not snore at all ☐ I don't know

The patient's snoring is:
☐ Soft ☐ Medium ☐ Loud ☐ Variably Present ☐ Always Present

The patient has trouble breathing normally during sleep when:
☐ Sleeping on back ☐ Sleeping sides ☐ All positions ☐ Never has trouble

The patient's snoring and/or breathing pattern can disrupt my sleep. ☐ yes ☐ no

The patient may snort, gasp, cough, or choke during sleep. ☐ yes ☐ no

The patient seems to have pauses in breathing or to stop breathing in sleep. ☐ yes ☐ no

The patient often is excessively sleepy during the day. ☐ yes ☐ no

The patient often has trouble staying awake while driving. ☐ yes ☐ no

The patient is often difficult to awaken in the morning. ☐ yes ☐ no

The patient awakens with pain. ☐ yes ☐ no

The patient often has difficulty with their memory and concentration. ☐ yes ☐ no

The patient often complains of a headache upon waking from sleep. ☐ yes ☐ no

The patient has an irregular sleeping / wake schedule. ☐ yes ☐ no

The patient's frequent arm, leg or body movements bother my sleep. ☐ yes ☐ no

The patient frequently exhibits unusual, abnormal behavior during sleep. ☐ yes ☐ no

The patient frequently has no energy for activities with family and friends. ☐ yes ☐ no

The patient frequently has trouble getting to sleep &/or falling asleep. ☐ yes ☐ no

The patient grinds teeth during sleep. ☐ yes ☐ no

The patient becomes very rigid during sleep. ☐ yes ☐ no

If you need to clarify any of your answers on the Bed Partner / Sleep Observer Questionnaire in more detail, have other important information about the patient's sleep or additional information about the patients overall medical condition, please feel free to describe your observations or concerns.