PRESBYTERIAN
Sleep Medicine

NEW PATIENT QUESTIONNAIRE (Age 13+)

Please fill out the front and back of all forms before your appointment and bring the completed form with you on that day. Thank you and we look forward to meeting you!

Name: Date: DOB:

Who is your primary care provider (PCP)?

Who referred you for a sleep evaluation if it was NOT your PCP?

What is your occupation?

What shift do you work? (Check current work shift)

Days ☐ Evenings ☐ Night shift/Swing shift ☐

CHIEF COMPLAINT: What is the primary reason for your visit to Presbyterian Sleep Medicine?

PRIOR EVALUATION AND TREATMENT: (check the correct response)

Have you ever had a sleep study? Yes ☐ No ☐

If yes, when and where was it performed?

Are you currently using CPAP? Yes ☐ No ☐

Have you used CPAP in the past but are currently not using it? Yes ☐ No ☐

If yes, when and why are you no longer using it?

SLEEP HYGIENE:

Weekday:

Time you get into bed | Time you get out of bed | #hrs in bed | #hrs sleeping

Weekend:

Time you get into bed | Time you get out of bed | #hrs in bed | #hrs sleeping

How long does it typically take you to fall asleep? ☐ minutes

Do you do any of the following?

Yes ☐ No ☐ Take naps during the day? (If yes, how many days/week? ☐ How long? ☐ Minutes)

Yes ☐ No ☐ Exercise routinely? (# days/week? ☐ Typically at what time? ☐)

Yes ☐ No ☐ Drink caffeine (coffee, tea, soda) within 2-3 hours of bedtime?

Yes ☐ No ☐ Drink alcohol within 2-3 hours of bedtime?

Yes ☐ No ☐ Use tobacco (smoked or chewed) within 2-3 hours of bedtime?

Do you do any of the following? (continued)

Yes ☐ No ☐ Watch TV or use other electronic devices (eg, cell phone, tablet, etc) in bed?

Yes ☐ No ☐ Take prescription or over-the-counter stimulants or sleep aides? Type ☐

Yes ☐ No ☐ Try to go to bed and wake up at the same time every day?

Yes ☐ No ☐ Have pet(s) sleeping on the bed?

Yes ☐ No ☐ Sleep better away from your own bed/bedroom?

Yes ☐ No ☐ Have "racing thoughts" or "inability to turn off your brain" when in bed?

SLEEP RELATED SYMPTOMS: (check the correct response)

- Difficulty falling asleep Yes ☐ No ☐
- Difficulty staying asleep Yes ☐ No ☐
- Waking up frequently from sleep Yes ☐ No ☐
  If yes, how many times per night ☐
- Snoring Yes ☐ No ☐
- Non-refreshing sleep Yes ☐ No ☐
- Daytime sleepiness Yes ☐ No ☐
- Stop breathing during sleep Yes ☐ No ☐
  If yes, witnessed by whom ☐
- Urinating frequently at night Yes ☐ No ☐
  If yes, how many times per night ☐
- Wake short of breath or wheezing Yes ☐ No ☐
- Waking up choking/gasping Yes ☐ No ☐
- Heartburn at night Yes ☐ No ☐
- Nasal congestion disrupting sleep Yes ☐ No ☐
- Excessive sweating at night Yes ☐ No ☐
- Dry mouth in the morning Yes ☐ No ☐
- Restless sleep Yes ☐ No ☐
- Headache on awakening Yes ☐ No ☐
- Frequent nightmares Yes ☐ No ☐
  If yes, during what part of the night ☐
- Pain that disrupts sleep Yes ☐ No ☐
  If yes, describe

- Uncontrollable urge to sleep Yes ☐ No ☐
- Muscle weakness w/ emotional experience Yes ☐ No ☐
- Sleep paralysis (can't move on awakening) Yes ☐ No ☐
- Sleep attacks (fall asleep without warning) Yes ☐ No ☐
- Dreaming/hallucinations at sleep onset Yes ☐ No ☐
- Sleep walking (current) Yes ☐ No ☐
  If yes, when was the last episode ☐
- Sleep walking (as a child) Yes ☐ No ☐
- Sleep talking Yes ☐ No ☐
- Movements of arms/legs during sleep Yes ☐ No ☐
- Acting out dreams Yes ☐ No ☐
  If yes, how often does this occur ☐
  Have you injured self/bed partner ☐
- Teeth grinding Yes ☐ No ☐
- Urge to move the legs at night Yes ☐ No ☐
- Sensation is worse at night Yes ☐ No ☐
- Sensation is worse with inactivity Yes ☐ No ☐
- Sensation improves with movement Yes ☐ No ☐
- Been told legs move excessively in sleep Yes ☐ No ☐
- Motor vehicle accident due to sleepiness Yes ☐ No ☐
- Near miss auto accident due to sleepiness Yes ☐ No ☐

EPWORTH SLEEPINESS SCALE: (please check the appropriate number for each question)

How likely are you to doze off or fall asleep in the following situations?
Use the following scale to tell us how likely you are to doze:

0 no chance	**1** slight chance	**2** moderate chance	**3** high chance

Sitting and reading	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Watching television	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting inactive in a public place (such as a theatre or meeting)	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total Score _____

FATIGUE SCALE: (circle the number that best describes your energy level over the past week or so)

Energetic
No Fatigue

Worst
Possible Fatigue

0 1 2 3 4 5 6 7 8 9 10

None — Mild Fatigue — Moderate Fatigue — Severe Fatigue

PAST MEDICAL HISTORY: (please circle all of your current or past medical problems)

High blood pressure	Stroke	GERD/Heartburn	Erectile dysfunction
Heart failure	High cholesterol	Diabetes	Hypothyroidism
Heart disease/heart attack	COPD/Emphysema	Depression	Fibromyalgia
Peripheral vascular disease	Asthma	Chronic sinus disease	Chronic pain

Please list any additional current or past medical problems:

MEDICATIONS: (please list all medications including supplements and over-the-counter medications)

Medicine	Dose	How many times a day?

ALLERGIES: (please list ALL medication and other allergies)

Medication or substance	Reaction

PAST SURGICAL HISTORY: (Please list any prior surgeries below. Be sure to include any prior surgeries to your upper airway (for example, tonsillectomy, septoplasty, UPPP, sinuses, etc.)

Type of Surgery	Year

FAMILY HISTORY: (please report information for blood relatives below)

MEDICAL PROBLEM	YES	NO	RELATIONSHIP (Father, Mother, Brother, Sister, Children)
Insomnia			
Narcolepsy			
Sleep Apnea			
Snoring			
Restless Legs			
Allergies/Hay Fever			
Anemia			
Cancer (if yes, list type)			
Depression			
Diabetes			
Kidney Disease			
Emphysema/COPD			
Heart Attack/Heart Disease (list age it occurred)			
Hypertension			
Stroke (list age it occurred)			

SOCIAL HISTORY:

Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Living with partner

Yes ☐ No ☐ Do you smoke currently? ☐ Packs per day ☐ # Years ☐ Age started

Yes ☐ No ☐ Are you a past smoker? ☐ Packs per day ☐ # Years ☐ Year quit

Yes ☐ No ☐ Do you drink alcohol? ☐ Drinks per day ☐ Drinks per week ☐ Type

Yes ☐ No ☐ Do you or have you used street drugs? ☐ Type

Yes ☐ No ☐ Do you drink caffeine? ☐ Drinks per day

Type: [ ] Coffee [ ] Tea [ ] Soda

REVIEW OF SYSTEMS:

PLEASE PUT A CHECK MARK in the box ONLY IF HAVING PROBLEMS.

Constitution	**Cardiovascular**	**Musculoskeletal**
Activity change	Chest pain	Joint pain
Appetite change	Leg swelling	Back pain
Chills	Palpitations	Gait problem
Sweating	Heart disease	Muscle pain
Fatigue	**Gastrointestinal**	Neck pain
Fever	GERD/reflux	**Neurological**
Unexpected weight change	**Endocrine**	Morning headaches
Hearing/Ear/Nose/Throat	Cold intolerance	Light headedness
Congestion	Heat intolerance	Seizures
Dental problem	Abnormally great thirst	Tremors
Hearing loss	Excessive hunger	Stroke
Postnasal drip	Excessive urination	**Hematologic**
Runny nose	**Genitourinary Female**	Swollen lymph nodes
Sinus pressure	Urinating frequently	Bruises/bleeds easily
Sneezing	Peri-menopausal	**Psychiatric**
Sore throat	Menopausal	Agitation
Eyes	**Genitourinary Male**	Behavior problem
Eye itching	Nocturia	Confusion
Respiratory	Difficulty urinating	Decreased concentration
Chest tightness	Bed-wetting (children)	Sad mood
Cough	Urinating frequently	Hyperactive
Shortness of breath	Urinating urgency	Nervous/anxious
Wheezing		Sleep disturbance
		Suicidal ideas