PATIENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS BELOW:

1. What problems do you have that led to this sleep study evaluation?

   _____
   _____
   _____
   _____

2. What time do you go to bed?

   _____

3. How long does it usually take for you to fall asleep?

   _____

4. How many times do you awake after falling asleep?

   _____

   REASONS:
   ☐Need to urinate
   ☐Shortness of breath
   ☐Palpitations (fast heart beat)
   ☐Anxiety
   ☐Other

5. Do you snore?
   ☐YES
   ☐NO
   ☐DON'T KNOW
   Describe your snoring:
   ☐Light
   ☐Occasional
   ☐Constant
   ☐Heavy
   ☐Other

6. While sleeping are you ever observed to stop breathing, choke, or gasp for air? Please describe…

   _____
   _____
   _____

7. What time do you wake up?

   _____

8. How do you feel in the morning upon wakening?
   ☐Refreshed
   ☐Groggy
   ☐Sleepy
   ☐Fatigued
   ☐Other: Explain_____

9. Do you ever awake with headaches?

   ☐YES ☐NO

10. Do you ever awaken with:
    ☐Chest Pain
    ☐Heartburn
    ☐Dry mouth
    ☐Nasal congestion

11. Do you fall asleep with quiet activities such as reading or watching television?

    ☐YES ☐NO

12. Do you fall asleep easily with purposeful activities (i.e., talking, eating)?

☐YES ☐NO

13. Do you take naps?

☐YES ☐ NO

If yes, how often?_____
How long?_____

14. Do you get sleepy while driving?

☐YES ☐ NO

15. Have you ever had an accident or "near miss" from falling asleep?

☐YES ☐NO

If yes, when? _____

16. While waiting to fall asleep do you feel an unsettled or restless sensation in your legs?

☐YES ☐NO

17. Do you ever get a sudden muscular weakness or even brief periods of paralysis (being unable to move) when laughing, angry, or in situations of strong emotions?

☐YES ☐NO

18. Has your weight been stable?

☐YES ☐NO

19. To rate your degree of sleepiness during the day, please respond by how likely you are to doze off or fall asleep during the day in the following situations, in contrast to just feeling tired.

0= NEVER
1= SLIGHT CHANCE
2=MODERATE CHANCE
3=HIGH CHANCE

EPWORTH SLEEPINESS SCALE

1. Sitting and reading 0 1 2 3
2. Watching television 0 1 2 3
3. Sitting inactive in Public place (i.e., a theater or meeting) 0 1 2 3
4. 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 quietly after lunch without alcohol 0 1 2 3
7. Sitting and talking With someone 0 1 2 3
8. In a car, while stopped for a few minutes in traffic 0 1 2 3

PLEASE ADD THE TOTAL SCORE____

PAST MEDICAL HISTORY

20. Do you have any of the following?

High blood pressure_____

If yes how many years?_____

Heart Disease_____

If yes how many years? _____

Nasal allergies or hay fever_____

Trouble breathing

through your nose _____

Asthma_____

Emphysema or

Chronic bronchitis_____

Strokes_____

Thyroid problems_____

Anxiety_____

Depression_____

Physical or emotional
trauma_____

SOCIAL HISTORY

21. Are you currently:

☐Employed

☐Retired

☐On Disability

☐Out of work

OCCUPATION:_____

22. Do you drink alcohol?

☐YES ☐NO

If yes, how much?_____

23. Have you ever used:
☐Tobacco
☐Cannabis
☐Other_____

24. Do you exercise?
☐YES ☐NO

Days per week_____
Type of exercise_____

25. Is there family history of sleep problems?
☐YES ☐ NO

26. Please list any other medical problems you have:
_____
_____
_____
_____
_____
_____
_____

27. Have you ever had tonsils and/or adenoids removed?

☐YES ☐NO

28. Please list previous hospitalizations or surgeries.
_____ YEAR_____
_____ YEAR_____
_____ YEAR_____
_____ YEAR_____

29. Please list medications:

_____
_____
_____
_____
_____
_____
_____
_____

30. Are you currently using a CPAP or BIPAP machine?

☐YES ☐NO

31. Where do you get your PAP supplies?

_____
_____

32. Do you use your insurance to pay for your equipment?

_____
_____

SLEEP STUDY PRE-SCREENING

33. Do you make frequent restroom trips during the night?

☐YES ☐NO

34. Do you use a cane or a wheelchair?

☐ YES ☐NO

35. Are you allergic to medical supplies such as latex or adhesive?

☐YES ☐NO

If yes what medical supplies and what is the reaction?

_____
_____

36. Do you experience panic attacks/anxiety?

☐YES ☐ NO

DOCTORS NOTES:

_____
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_____ _____

PATIENT SIGNATURE DATE PHYSCIAN SIGNATURE DATE