



## New Patient Questionnaire

Please complete this entire questionnaire with someone who has recently watched you sleep!  
And please ask this person to come with you to your initial evaluation, if he or she possibly can.

Name:	DOB:	AGE:
Sex:      Male      Female	Date of Evaluation:	
Home Phone#:	Cell Phone#:	
Work Phone#:	Emergency Contact Phone#:	
Who Referred you here?		
Which of your doctors do you want us to send reports to?		
Who helped you complete your questionnaire? (Circle): Bed-Partner Parent Child Other:		

**Briefly describe your main sleep problem:** \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Have you had a previous Sleep Disorder evaluation? \_\_\_\_\_ If so, where: \_\_\_\_\_

**Please check “never”, “occasionally”, or “frequently” for each symptom:**

Symptom	Never	Occasionally	Frequently
Snore Loudly?			
Wake choking or gasping?			
Feel fatigued?			
Awaken not feeling rested?			
Have memory problems?			
Awaken with a headache?			
Have trouble functioning?			
Have morning “dry mouth”?			
Have night time heartburn?			
Have “night sweats”?			
Awaken yourself snoring?			
Urinate at night?			
Smother lying on your back?			
Have a rapid heartbeat at night?			

How do you feel when you wake up? \_\_\_\_\_

**Do you seem to have problems with your breathing while asleep?** \_\_\_\_\_

Please describe the problem: \_\_\_\_\_

For how long have you had this problem? \_\_\_\_\_ How often does it occur? \_\_\_\_\_

What factors make this problem worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What percent of the night do you think that you sleep on your back? \_\_\_\_\_

**Do you have problems with daytime sleepiness?** \_\_\_\_\_

Do you have problems staying awake? \_\_\_\_\_

Please describe the problem: \_\_\_\_\_

For how long have you had this problem? \_\_\_\_\_ How often does it occur? \_\_\_\_\_

**Epworth sleepiness Scale:** How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? 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 scale to choose the **most appropriate number** for each situation.

0 = would **Never** doze

1 = **Slight** chance

2 = **Moderate** chance

3 = **High** chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (ex: a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down in the afternoon when circumstances permit	
Sitting and Talking to someone	
In a car, while stopped for a few minutes in traffic	
Sitting quietly after lunch without alcohol	
<b>TOTAL</b>	

In what situations do you have the most problems staying awake? \_\_\_\_\_

How often do you “nod off”, even just for a second, without meaning to? \_\_\_\_\_

Have you ever “nodded off” while driving? \_\_\_\_\_ How recently? \_\_\_\_\_

Ever had a “close call” from sleepiness while driving? \_\_\_\_\_ An accident? \_\_\_\_\_

How many miles do you drive in a day? \_\_\_\_\_ Do you work around dangerous machinery? \_\_\_\_\_

How many “crashes” have you had over the past two years? \_\_\_\_\_

Have you had sudden spells of muscle weakness (not fatigue) without clear cause? \_\_\_\_\_

Were these spells associated with laughter, anger, or being startled? \_\_\_\_\_

Have you ever felt totally paralyzed upon awakening or when falling asleep? \_\_\_\_\_

Have you ever felt you’ve seen or heard something not actually there upon awakening or when falling asleep? \_\_\_\_\_

**Do you have problems with unusual discomforts, movements, or behaviors at night?** \_\_\_\_\_

Please describe the problem: \_\_\_\_\_

Please **check Never, Occasionally, or Frequently** for each symptom and **circle how it disrupts you sleep.**

Symptom	Never	Occasionally	Frequently	How much does this disrupt your sleep?
“Restless legs” at bedtime?				Minimally Mildly Moderately Severely
Restless Sleep (“tossing and turning”)?				Minimally Mildly Moderately Severely
Tooth Grinding or Clenching at night?				Minimally Mildly Moderately Severely
Rhythmic Leg or Arm Jerks While asleep?				Minimally Mildly Moderately Severely
Sleepwalking?				Minimally Mildly Moderately Severely
Bad Nightmares or “Flashbacks”?				Minimally Mildly Moderately Severely
“Acting Out” your Dreams?				Minimally Mildly Moderately Severely

Any other unusual sleep behaviors? \_\_\_\_\_

**Do you have problems with being unable to get to sleep or stay asleep?** \_\_\_\_\_

Please describe the problem: \_\_\_\_\_

For how long have you had this problem? \_\_\_\_\_ How often does it occur? \_\_\_\_\_

What factors make this problem worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

How often does it take you over 30 minutes to fall asleep? \_\_\_\_\_ Why? \_\_\_\_\_

What do you do when you can't fall asleep? \_\_\_\_\_

How often do you wake up in the night for over 30 minutes? \_\_\_\_\_ Why? \_\_\_\_\_

What do you do when you can't get back to sleep in the night? \_\_\_\_\_

Do you “clock-watch” at night? \_\_\_\_\_ Do you use an alarm clock? \_\_\_\_\_

Do you dread bedtime? \_\_\_\_\_ Do you sleep better when you are away from home? \_\_\_\_\_

**What are your work hours and days?** \_\_\_\_\_

Describe current job & Employer: \_\_\_\_\_

How well are you functioning at work? \_\_\_\_\_

Sleep Routine	On Work Days	On Non-Work Days
“Lights-Out” time:		
“Rise” time:		
Estimated total hours of sleep per night:		
How long to fall asleep, on average?		
How many awakenings in the night?		
How often do you wake up too early?		
How often do you nap?		

How many hours of sleep do you think you need? \_\_\_\_\_

Are you more of a “night owl” or more of a “morning person”? \_\_\_\_\_

**Please describe any other sleep problems you have here:** \_\_\_\_\_

How do your sleep problems affect your daily life and activities? \_\_\_\_\_

**Who else in your family seems to have (or have had) your sleep problem?** \_\_\_\_\_

Have any of your close blood relatives had problems with: (please check and specify who):

- Loud Snoring: \_\_\_\_\_  Daytime Sleepiness: \_\_\_\_\_  Chronic Insomnia: \_\_\_\_\_
- Depression: \_\_\_\_\_  Anxiety/Panic disorder: \_\_\_\_\_  Alcohol/Drug Problem: \_\_\_\_\_
- High Blood Pressure: \_\_\_\_\_  Heart Disease: \_\_\_\_\_  Diabetes: \_\_\_\_\_

**Marital Status/Living Arrangements:** \_\_\_\_\_

Number of children, and ages: \_\_\_\_\_

Highest grade completed in school: \_\_\_\_\_

How much do you smoke or chew tobacco? \_\_\_\_\_ How often within 45 min. of bedtime?

How much alcohol, including beer, do you consume? \_\_\_\_\_ Within 4 hrs. of bedtime? \_\_\_\_\_

How much caffeine (coffee, tea, Coke, etc.) do you consume? \_\_\_\_\_ When? \_\_\_\_\_

How often do you get planned exercise? \_\_\_\_\_ How much? \_\_\_\_\_

Please tell us about any recreational drug use: \_\_\_\_\_

**Significant illnesses, surgeries or hospitalizations :** \_\_\_\_\_

X	Problem or Event	Date	X	Problem or Event	Date
	Recent Blood Test for Thyroid Function?			Liver Problems (Such as Hepatitis)?	
	Tonsillectomy?			Kidney, Bladder or Urine Problems?	
	Nasal Trauma?			Anemia?	
	Recurrent Sinus Infection?			Thyroid Disease?	
	Seasonal Allergies ("Hay Fever")			[Males] Prostate Problems?	
	Head Injury with Unconsciousness?			[Males] Impotence?	
	Seizures or Epilepsy?			Arthritis or Chronic Pain? (Where?)	
	Migraine or Cluster Headaches?			Fibromyalgia or CFS?	
	Parkinson's or Alzheimer's Disease?			Diabetes?	
	Neuropathy?			Obesity?	
	Heart Disease? (Specify Type)			Cancer or Immune System Problems?	
	High Blood Pressure?			Depression Problems?	
	Stroke or Heart Attack?			Anxiety or Panic Disorder?	
	Emphysema (COPD/ Chronic Bronchitis)?			Attention Deficit/ADHD?	
	Asthma?			Other "Stress" Problems? (Specify)	
	Other Lung Disease? (Specify)			Alcohol or Drug Dependence or Problems?	
	Ulcers or Hiatal Hernia?			Psychiatric or Psychological Treatment?	
	Reflux ("Heartburn")			Other Medical History? (Specify)	

Have you ever had any of the following problems (or events) in the past? If so please (X) and give date:

Please "X" any and all current problems or symptoms which you are having:

**CONSTITUTIONAL**

- Weight gain in past year  
How many pounds? \_\_\_\_\_
- Weight loss in past year  
How many pounds? \_\_\_\_\_
- Fever
- Chills
- Poor Appetite
- Sleep Poorly

**EYES**

- Decreased vision
- Glasses or contacts
- Pain in eyes

**EAR, NOSE & THROAT**

- Earaches
- Ringing in Ears
- Loss of Hearing
- Sinus problems
- Nose congested or runny
- Postnasal drainage
- Frequent sneezing
- Recurrent sore throats
- Persistent hoarseness
- Dental problems

**ALLERGIC/IMMUNE**

- Positive allergy test  
To what? \_\_\_\_\_

**HEART & VASCULAR**

- Heart murmur
- Rapid or irregular Beat
- Swelling in leg or ankle
- Sleeping propped up

**RESPIRATORY**

- Chest pain
- Frequent Cough
- Wheezing
- Coughing up sputum
- Coughing up blood

Shortness of breath:

- At rest
- Walking on level ground
- On hills or steps

**GASTROINTESTINAL**

- Frequent heartburn
- Frequent indigestion
- Nausea
- Abdominal pain
- Blood in Stool

**GENITOURINARY**

- Painful urination
- Blood in urine
- Frequently urination
- FOR WOMEN ONLY**
- Irregular periods
- Bleeding between periods
- Post menopause

**MUSCULOSKELETAL**

- Painful joints
- Swollen or red joints
- Back pain
- Sore muscles

**SKIN & BREASTS**

- Rash
- Enlarging/changing mole
- Lump in breast
- Nipple discharge
- NEUROLOGIC**
- Severe headaches
- Dizziness
- Passing out/fainting
- Loss of Feeling: hands/ft

**HEMATOLOGIC**

- Easy bruising
- Abnormal bleeding
- Swollen lymph glands

**ENDOCRINE**

- Any steroid tablets/inject.

**PSYCHOLOGIC**

- Significant life stress  
Rate stress (0-10): \_\_\_\_\_
- Feeling chronic anxiety
- Feeling depressed
- Lack of energy
- Not enjoying life
- Excessive self-criticism
- Concentration problems
- Lethargy
- Sexual difficulties
- Recent irritability
- Wanting to be alone
- Panic episodes
- Obsessions/compulsions
- Phobias (of what?): \_\_\_\_\_

**Fort Sanders Regional Medical Center / Sleep Center  
HOME MEDICATION LIST**

<p><b>Patient Label</b> (Office use only)</p>
---

Pharmacy Name: \_\_\_\_\_

Pharmacy Phone#: \_\_\_\_\_ Pharmacy Fax#: \_\_\_\_\_

**ALLERGIES**

NO Allergies      Pregnant or Lactating?  Yes  No

Medication:	Allergy symptoms (Hives, Itching, Anaphylaxis, etc.)

**CURRENT MEDICATIONS** (Including OTC/Herbals):

NO Home Medications

DRUG NAME	DOSE	FREQUENCY	STOP DATE
		<input type="checkbox"/> PRN <input type="checkbox"/> Twice daily <input type="checkbox"/> Four times daily <input type="checkbox"/> Daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	
		<input type="checkbox"/> PRN <input type="checkbox"/> Twice daily <input type="checkbox"/> Four times daily <input type="checkbox"/> Daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	
		<input type="checkbox"/> PRN <input type="checkbox"/> Twice daily <input type="checkbox"/> Four times daily <input type="checkbox"/> Daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	
		<input type="checkbox"/> PRN <input type="checkbox"/> Twice daily <input type="checkbox"/> Four times daily <input type="checkbox"/> Daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	
		<input type="checkbox"/> PRN <input type="checkbox"/> Twice daily <input type="checkbox"/> Four times daily <input type="checkbox"/> Daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	
		<input type="checkbox"/> PRN <input type="checkbox"/> Twice daily <input type="checkbox"/> Four times daily <input type="checkbox"/> Daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	
		<input type="checkbox"/> PRN <input type="checkbox"/> Twice daily <input type="checkbox"/> Four times daily <input type="checkbox"/> Daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	
		<input type="checkbox"/> PRN <input type="checkbox"/> Twice daily <input type="checkbox"/> Four times daily <input type="checkbox"/> Daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	
		<input type="checkbox"/> PRN <input type="checkbox"/> Twice daily <input type="checkbox"/> Four times daily <input type="checkbox"/> Daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	

**This Section to be completed by Sleep Center Staff**

Home medication list updated/verified by: \_\_\_\_\_ Date/Time: \_\_\_\_\_  
 Home medication list updated/verified by: \_\_\_\_\_ Date/Time: \_\_\_\_\_  
 Home medication list updated/verified by: \_\_\_\_\_ Date/Time: \_\_\_\_\_  
 Home medication list updated/verified by: \_\_\_\_\_ Date/Time: \_\_\_\_\_

**Home Medications prescribed by Fort Sanders Sleep Center**

Name of Drug	Dose	Frequency	Reason	Nurse/MD Signature	Date/Time

Patient Signature \_\_\_\_\_ Date/Time: \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date/Time: \_\_\_\_\_