SLEEP HEALTH SOLUTIONS

Name:_____

Date: _____/_____/_____ **Gender M / F**

Date of Birth:_____/_____/_____ **Age:** _____

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New Patient Questionnaire

Referring Provider:_____ **Primary Care Provider:** _____

Cardiologist: _____ **Pulmonologist:**_____

What is your primary problem with sleep? _____

How long have you had this problem? _____

Were you ever diagnosed with a sleep problem in the past? ☐Yes ☐No

If Yes, a) Treating physician b) what was the diagnosis c) recommended treatment d) location and date of previous testing

a)_____ b) _____

c)_____

d)_____

Are you currently using your treatment while you sleep? ☐Yes ☐No

What is the name of the equipment company providing supplies? _____

Do you have or has anyone noticed that you have the following symptoms?

☐Snoring

☐Awakened by your own snoring

☐Wake up gasping for air

☐Stop breathing while asleep

☐Wake up with a dry mouth/sore throat

☐Nighttime wheezing

☐Wake with heart racing, smothering or panic

☐Have morning headaches

☐Episodes of confusion

☐Gained weight in the last year; How much _____

☐Congestion at night

☐Restless sleep

☐Heartburn/gastric reflux at night

Have you had sudden weakness with excitement, laughter, anger or surprise? ☐Yes ☐No

Do you feel paralyzed as you fall asleep or wake up? ☐Yes ☐No

Have you ever seen or heard things that aren't there while falling asleep or while waking up? ☐Yes ☐No

As an adult, do you sleep walk? ☐Yes ☐No

Do you act out dreams? ☐Yes ☐No

Have you had seizures during sleep? ☐Yes ☐No

Do you grind your teeth in your sleep? ☐Yes ☐No

What is your typical sleep schedule on **work** days? Bedtime:_____ am/pm; Rise Time:_____ am/pm

What is your typical sleep schedule on **off** days? Bedtime: _____am/pm; Rise Time: _____am/pm

How many times do you wake up during the night? _____ How many of those for restroom visits?_____

How long does it usually take you to fall back asleep? _____

How many hours do you usually sleep on work days? _____ On off days?_____

Do you feel excessively sleepy in the daytime? ☐Yes ☐No

Do you nap during the day? ☐Yes ☐No If yes, how often and for how long?_____

Are you refreshed by a typical night's sleep? ☐Yes ☐No Are your naps refreshing? ☐Yes ☐No

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Do you kick your legs during sleep? ☐Yes ☐No

Do you have a restless or uncomfortable sensation in legs? ☐Yes ☐No

Do you have an urge to move your legs at night? ☐Yes ☐No

Do your legs prevent you from falling asleep? ☐Yes ☐No

Does movement of the legs help? ☐Yes ☐No

Past Medical History: (Do you have any of the following)

☐High Blood Pressure	☐Diabetes	☐Asthma
☐Coronary Artery Disease	☐hepatitis	☐COPD/Emphysema
☐Heart Valve Disease	☐concussion	☐Rheumatoid/AutoImmune Disease
☐Congestive Heart Failure	☐Stroke	☐Fibromyalgia
☐Heart Attack (Date:_____)	☐Thyroid Disease	☐Arthritis
☐Cardiac Stent	☐seizures	☐Parkinson's Disease
☐Depression	☐Anxiety	☐PTSD
☐Tonsillectomy	☐ Drug/Alcohol Addiction	☐ Gastric reflux or hiatal hernia
☐ Kidney disease		

☐Other:_____

Past Surgical History:

_____

_____

_____

_____

Family History: (circle all that apply)

Heart Disease	**Heart Attack**	**Stroke**	**Diabetes**
Sleep Apnea	**COPD/Emphysema**	**Mental Illness**	**Thyroid Disease**

Social History:

Occupation: _____

Do you work at night or do shift work? ☐Yes ☐No Hours?_____

Marital Status: _____ Who do you live with? _____

Caffeine Intake:☐Yes ☐No If yes, How much? _____A.M. _____ P.M.

Do you or have you ever smoked or chewed tobacco? ☐Yes ☐No

If yes, number of packs/day _____ number of years _____ if quit, when did you quit? _____

Do you drink alcohol? ☐Yes ☐No If yes, How much? _____

Do you currently use recreational drugs? ☐Yes ☐No If yes, describe? _____

Review of Systems (please mark all that apply)

GENERAL
- ❑ weight gain
- ❑ unintentional weight loss
- ❑ loss of appetite
- ❑ increase appetite
- ❑ night sweats
- ❑ fever

NEUROLOGICAL
- ❑ headache
- ❑ memory loss
- ❑ poor concentration
- ❑ weakness
- ❑ abnormal sensation in extremities
- ❑ tremor
- ❑ dizziness

GASTROINTESTINAL
- ❑ change in bowel habits
- ❑ abdominal pain
- ❑ vomiting
- ❑ nausea
- ❑ heartburn
- ❑ skin or eyes turning yellow
- ❑ difficulty swallowing

Eyes
- ❑ blurry vision
- ❑ cataracts
- ❑ double vision
- ❑ bothered by bright light
- ❑ vision changes

RESPIRATORY
- ❑ shortness of breath
- ❑ chronic cough
- ❑ coughing up blood
- ❑ wheezing

SKIN
- ❑ skin irritation
- ❑ rash
- ❑ itching
- ❑ wounds

PSYCHIATRIC
- ❑ depression
- ❑ anxiety
- ❑ stress
- ❑ worry

ENT
- ❑ stuffy nose
- ❑ runny nose
- ❑ nose bleeds
- ❑ sores on nose
- ❑ dry mouth
- ❑ impaired hearing
- ❑ ringing in ears
- ❑ sore throat

CARDIOVASCULAR
- ❑ chest pain
- ❑ passing out or feeling like you may
- ❑ pain in legs with exertion
- ❑ difficulty breathing when lying down
- ❑ waking short of breath
- ❑ palpitations
- ❑ ankle swelling
- ❑ blood pressure changes

MUSKULOSKELETAL
- ❑ joint pains
- ❑ muscle pain
- ❑ joint swelling
- ❑ stiff joints
- ❑ back pain

Neck
- ❑ pain
- ❑ recent injury
- ❑ masses
- ❑ stiffness

URINARY
- ❑ frequent urination
- ❑ incontinence

ENDOCRINE
- ❑ intolerance of heat
- ❑ intolerance of cold
- ❑ increased thirst

HEMATOLOGY
- ❑ easy bruising
- ❑ blood clots
- ❑ anemia

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situation?
If you are on treatment for a sleep disorder (sleep apnea, narcolepsy, etc), please answer questions about sleepiness ON YOUR CURRENT TREATMENT (CPAP, BIPAP, stimulant therapy, etc)

Situation	Never (0)	Slight (1)	Moderate (2)	High (3)
Sitting and Reading				
Watching TV				
Sitting, inactive in a public place (theatre, meeting)				
As a passenger in a car for a hour without a break				
Lying down to rest in the afternoon				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few mins in traffic				

Are you allergic to latex? ☐Yes ☐No

Medication Allergies: _____

Medication	Dosage	Route	Frequency	Indications