sleephealth
clinic of The Woodlands

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CONFIDENTIAL PATIENT QUESTIONNAIRE

Name: _____ Date:_____ Date of Birth: _____

Referral Source:_____

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Previous PSG?
Y N

What is your primary concern/problem regarding your sleep?

_____

_____

_____

How long have you had this concern/problem? _____ # of months/years

Not including your primary care physician or referring doctor, have you seen another doctor for your sleep problem? ❒ Yes ❒ No

If yes, who was the doctor and when were you seen?

_____

_____

If yes, what was the diagnosis? _____

Did you have a sleep study? ❒ Yes ❒ No
If yes, when and where? _____

_____

What treatment, if any, was recommended? _____

_____

Was the treatment effective? ❒ Yes ❒ No

Do you have any allergies or reactions to drugs? ❒ Yes ❒ No

If yes, specify drug and reaction: _____

_____

_____

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Medical History

Check the appropriate boxes if you have/have had any of the following conditions:

- ❒ Allergies
- ❒ Anemia/blood disease
- ❒ Arthritis/rheumatism
- ❒ Asthma
- ❒ Cancer
- ❒ Depression
- ❒ Diabetes (Type I/II)
- ❒ Emphysema or Chronic Bronchitis
- ❒ Other Lung Disease
- ❒ Ulcers/intestinal disease
- ❒ Heartburn/acid reflux
- ❒ Heart disease
- ❒ High blood pressure
- ❒ High cholesterol/triglycerides
- ❒ Kidney/bladder disease
- ❒ Liver disease
- ❒ Menopause
- ❒ Mental illness
- ❒ Seizures
- ❒ Sinusitis
- ❒ Stroke
- ❒ Thyroid disease (Hypothyroidism/Hyperthyroidism)
- ❒ Other

_____
_____
_____
_____
_____

Have you had your tonsils removed? ❒ Yes ; At what age? _____ ❒ No

Have you had nose and/or throat surgery? ❒ Yes; At what age? _____ ❒ No

Please list any other surgeries and/or hospitalization you have had:

Date	Reason

(If more spaces is needed, please continue on the back of this page)

Family History

Check the appropriate boxes if your family members have had any of the following conditions:

Medical	**N**	**Y**	**Father**	**Mother**	**Siblings**	**Children**
Cancer			❒	❒	❒	❒
Depression			❒	❒	❒	❒
Diabetes			❒	❒	❒	❒
Heart disease			❒	❒	❒	❒
High blood pressure			❒	❒	❒	❒
Stroke			❒	❒	❒	❒
Sleep	**N**	**Y**				
Insomnia			❒	❒	❒	❒
Narcolepsy			❒	❒	❒	❒
Restless legs			❒	❒	❒	❒
Sleep apnea			❒	❒	❒	❒
Snoring			❒	❒	❒	❒

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Social History

Occupation and place of employment: _____

_____

What is your work schedule? _____

_____

Marital status: ❒ Single ❒ Domestic Partner ❒ Married
❒ Separated ❒ Divorced ❒ Widowed

Number of children and ages: _____

EtOH

Do you currently drink alcohol? ❒ Yes ❒ No

Do you have a drink just prior to going to bed? ❒ Yes ❒ No

Do you have a history of alcohol abuse/chemical dependency? ❒ Yes ❒ No

Tobacco

Do you currently use tobacco products? ❒ Yes ❒ No/never ❒ No/stopped

If yes, Pipe ____# daily for ____months/years

Cigarettes ____# daily for ____months/years

Cigars ____# daily for ____months/years

Other_____ ____#daily for _____months/years

If you had a history of tobacco usage but have quit using them, when did you quit and what products did you previously use? _____

_____

Caffeine

Do you currently drink caffeinated beverages? ❒ Yes ❒ No

If yes, _____ # of cans of soft drinks daily

_____ # of cups of coffee daily

_____ # of cups/glasses of tea daily

_____ # of cups/glasses of cocoa/chocolate milk

Weight Status

Your current weight: _____ Height: _____

Are you on a diet? ❒ Yes ❒ No

What kind of diet? _____ For how long? _____

Do you exercise? ❒ Yes ❒ No

If yes, what type(s) of exercise and how often?_____

_____

_____

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Has your weight changed recently? ❒ Yes ❒ No

If yes, gain/loss of _____ lbs over _____months/years

Approximately how much did you weigh at age 18 years? _____ lbs

Mood

Do you feel depressed? ❒ Yes ❒ No
If yes, ❒ rarely ❒ occasionally ❒ frequently

Has your spouse/friends commented about you being irritable? ❒ Yes ❒ No

Do you (or others) feel you have had a recent personality change?
❒ Yes ❒ No If yes, specify: _____

_____

_____

Sleep Hygiene

On weekdays/workdays, what time do you:
Go to bed? _____ a.m./p.m. Get up? _____ a.m./p.m.

On weekend/days off, what time do you:
Go to bed? _____ a.m./p.m. Get up? _____a.m./p.m.

Do you take naps during the day? ❒ Yes ❒ No
If yes, how many naps daily? _____

Are these naps refreshing? ❒ Yes ❒ No

How long do these naps last?_____ minutes/hours

Are any of your naps involuntary? ❒ Yes ❒ No
If yes, when do they occur?: _____

_____

Do you eat, argue, worry, write, and/or read in bed? ❒ Yes ❒ No
If yes, specify: _____

_____

_____

Do any of your children and/or pets sleep in the bedroom with you?

❒ Yes ❒ No If yes, please specify: _____

_____

What would be an ideal sleep schedule for you?

Go to bed at _____ a.m./p.m. Get up at_____ a.m./p.m.

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Insomnia

Do you have difficulty falling asleep? ❒ Yes ❒ No

If yes, how long does it take? _____ # minutes/hours ____# of nights weekly

Do you have several awakenings during the night? ❒ Yes ❒ No

If yes, _____ # of times nightly _____ # of nights weekly

Why do you awaken?_____

_____

Do you have extended periods of wakefulness during the night?

❒ Yes ❒ No If yes, _____ # minutes/hours _____ # of nights weekly

Do you awaken too early in the morning and stay awake? ❒ Yes ❒ No

Parasomnias

If yes, at what time_____ a.m. _____ # of times weekly

Some of the following questions will ask you to rate the frequency of certain symptoms. If you check yes to any of the boxes, please use the scale below as a guide when answering the questions.

Frequently = 1 or more times per week
Occasionally = 1 or more times per month
Rarely = the issue occurs but it is less than the above

Did you have any sleep problems as a child? ❒ Yes ❒ No

If yes, specify:_____

_____

_____

Do you **currently**:

Have intense nightmares or night terrors? ❒ Yes ❒ No
If yes, ❒ rarely ❒ occasionally ❒ frequently

Grind or clinch your teeth at night? ❒ Yes ❒ No
If yes, ❒ rarely ❒ occasionally ❒ frequently

Talk in your sleep? ❒ Yes ❒ No
If yes, ❒ rarely ❒ occasionally ❒ frequently

Hypersomnia

Walk in your sleep? ❒ Yes ❒ No
If yes, ❒ with or ❒ without eating;
❒ rarely ❒ occasionally ❒ frequently

Have incontinence of urine during sleep? ❒ Yes ❒ No
If yes, ❒ rarely ❒ occasionally ❒ frequently

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Are you sometimes drowsy while driving? ❒ Yes ❒ No
If yes, ❒ usually ❒ occasionally
❒ only on long highway trips

Have you ever had an accident or near miss because of dozing while driving?

❒ Yes ❒ No If yes, when and describe _____

_____

_____

For the following situations, indicate the chance of dozing or falling asleep (not feeling tired) by using the scale below:

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	_____
Watching TV	_____
Sitting inactive in a public place (e.g., a meeting or a theatre)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car while stopped for a few minutes in traffic	_____
Total =	_____

Sleep Prl

Have you ever been unable to move or paralyzed as you were falling asleep or waking up? ❒ Yes ❒ No If yes, describe:_____

_____

Cpxy

Have your ever felt sudden muscle weakness when you laughed, were surprised, or were angry? ❒ Yes ❒ No If yes, describe: _____

_____

_____

Hh

RO - Nar/MSLT

Have you ever had exceptionally vivid dreams *as you were falling asleep or waking up*? ❒ Yes ❒ No If yes, describe:_____

_____

_____

_____

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PLMS

Has your bed partner ever complained that you move excessively in your sleep? ❒ Yes ❒ No If yes, ❒ rarely ❒ occasionally ❒ frequently

Do you awaken yourself by kicking your legs?

❒ Yes ❒ No If yes, ❒ rarely ❒ occasionally ❒ frequently

RLS

Has your bed partner ever complained of leg kicks?

❒ Yes ❒ No If yes, ❒ rarely ❒ occasionally ❒ frequently

Do you have a restless sense of discomfort in your legs while resting or before falling asleep? ❒ Yes ❒ No If yes, ❒ rarely ❒ occasionally ❒ frequently

If yes, describe:_____

OSAS

Do you snore? ❒ Yes ❒ No ❒ Unknown

If yes, is it ❒ occasionally or ❒ continuously;

and is it ❒ only on your back or ❒ in any position.

Indicate the severity of your snoring by using the scale below:

☐ Grade 1: Heard only if you listen close to the face

☐ Grade 2: Heard in the room

☐ Grade 3: Heard just outside the bedroom with the door open

☐ Grade 4: Heard outside the bedroom with the door closed

Have your been told you stop breathing during sleep?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Do you ever awaken gasping for air?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Do you awaken with a dry mouth?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Do you awaken with nasal congestion?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Do you awaken with morning headaches?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Do you awaken with a sore throat?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

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Do you have night sweats?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Do you have heartburn at night?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Do you feel unrefreshed after sleeping?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Do you have problems with memory or concentration?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

Are you ever confused in the morning?

❒ Yes ❒ No If yes, ❒ rarely ❒occasionally ❒ frequently

On the average, how many times per night do you awaken to urinate? ____

Please tell us if there are any other concerns that you have about your sleep that were not covered in the above questionnaire:

_____

_____

_____

Thank you for taking the time to fill out this questionnaire. We look forward to seeing you at your scheduled consultation.

The Staff of the Sleep Health Clinic

of The Woodlands