SUNSET SLEEP
& WELLNESS CENTER

New Patient Sleep Questionnaire

**IF YOU HAVE A CPAP, PLEASE BRING DATA CARD OR THE CPAP DEVICE WITH YOU TO APPOINTMENT.

Date: _____

Patient name:_____

Referred by: _____

PCP (if different than referred by): _____

Please describe the reason you are being referred/seen today:

_____

_____

Sleep Schedule:	**Weekdays**	**Weekends**
What is your usual bedtime?		
How long does it take you to fall asleep?		
Do you wake frequently throughout the night?		
What time do you wake up in the morning?		
What time do you get out of bed in the morning?		
Do you take naps during the day?		
Do you work nights or shift work?		

Epworth Sleepiness Score: How likely are you to doze off in the following situations?

0 = Never 1= Slight chance 2= Moderate chance 3= High chance

_____ Sitting and reading

_____ Watching television

_____ Sitting inactive in a public place

_____ Passenger in a car for an 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 minutes in traffic (in driver's seat)

_____ TOTAL

Sleep history:

Do you **currently** experience any of the following? (check all that apply)

	Yes	No
Excessive daytime sleepiness		
Drowsy driving		
Difficulty falling asleep		
Difficulty staying asleep		
Snoring		
Wake up gasping, choking or feeling short of breath		
Witnessed apneas (someone telling you hold your breath or stop breathing during sleep)		
Do you feel refreshed when you wake up in the morning?		
Do you feel excessively fatigued or have low energy during the day?		
Nighttime heartburn or indigestion		
Morning headaches (on awakening)		
Frequent nasal congestion		
Waking up with dry mouth or sore throat		
Do you sleep with your mouth open?		
Frequent urination at night • If yes, how many times?		
Chronic pain that keeps you awake • If yes, location of pain?		
Unpleasant sensations in your legs at night or bedtime		
Is this unpleasant leg sensation associated with the urge to move? • If yes, does the discomfort improve with movement?		
Frequent disturbing dreams or nightmares		
Unusual movements or behaviors during sleep		
Sleepwalking		

Sudden weakness or loss of muscle tone when laughing, get excited or angry (i.e. knee buckling, jaw dropping, falling to the ground)		
Imagine seeing or hearing things as you fall asleep or wake up		
Feeling unable to move (paralyzed) as you fall asleep or wake up		
Teeth clenching or grinding during sleep		
Act out dreams during sleep (i.e. yell, punch, kick or other movements in the setting of a dream)		

Sleep studies and CPAP use (if applicable):

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

If so, when and where? When: _____

Name of facility: _____

Have you ever been diagnosed with a sleep disorder? If yes, what type? _____

Have you been prescribed a CPAP? Yes ☐ No ☐

If yes, are you currently using? Yes ☐ No ☐ What pressure? _____

If yes, what DME company do you get supplies from? _____

Medical History:

Do **<u>you</u>** have or have had any of the following?

☐ Coronary artery disease	☐ High blood pressure	☐ Parkinson's disease
☐ Heart attack	☐ Asthma	☐ Deviated nasal septum
☐ Congestive heart failure ○ EF if known _____	☐ COPD	☐ Surgery on the nose
☐ Atrial fibrillation	☐ Pulmonary hypertension	☐ Tonsillectomy
☐ Cardiac pacemaker/ICD	☐ Gastric reflux (heartburn)	☐ Anemia

☐ Stroke/TIA	☐ Seasonal allergies	☐ Chronic pain
☐ Hypothyroidism	☐ Depression	☐ Restless leg sydrome
☐ Diabetes Mellitus	☐ Anxiety	☐ Vitamin D deficiency
☐ Migraines	☐ Fibromyalgia	☐ Kidney disease
☐ Seizure disorder/ epilepsy	☐ ADHD	☐ Post-traumatic stress disorder

Other medical problems not listed above? _____

_____

Family medical history:

Does anyone in your **family** have the following?

☐ Sleep apnea	☐ Narcolepsy	☐ Restless leg syndrome
☐ Snoring	☐ Night terrors	☐ Sleep walking (as adult)
☐ Insomnia	☐ REM Behavior Disorder	☐ Parkinson's disease ☐ Seizure Disorder

Other significant family history?

_____

_____

Social History:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Do you share your bed with (circle all that apply) ☐ Significant other ☐ Children ☐ Pets

Occupation: _____

Do you smoke cigarettes? Yes ☐ No ☐ Quit (former smoker) ☐

If current smoker, how many packs per day? _____ Smoked how many years? _____

If quit, when? _____ How many years did you smoke? _____

How many caffeinated beverages (coffee, tea, soda) do you drink in a day? _____

What is the latest time in the day you consume a caffeinated beverage? _____

Assuming one beer, one glass of wine or one shot of liquor is one drink, how many drinks do you consume **each day** on weekdays? _____ weekends? _____

Do you currently use any recreational drugs (i.e. marijuana, cocaine)? Yes ☐ No ☐

If yes, describe: _____

How many times a week do you exercise? _____

Medications:

What sleep medications, including over the counter, have you tried in the past?

_____

Do you take any medication for chronic pain or muscle spasms? If so, what and how often?

_____

Please list current medications:
