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Sleep/Medical Questionnaire

Name: _____ Date: _____

Referring Physician_____

Date of Birth _____ Marital Status _____ Number of Children _____

Please try to answer all questions. If possible, obtain the assistance of your bed-partner.

1. **Describe your main sleep problem, including when and how this began:**

_____

_____

2. Extent of problem:

How long have you had this problem? □ months _____ □ years ____

How often does this problem occur? □Almost every night □ Other _____

How severe is the problem? □ Mild □ Moderate □ Severe

3. Prior evaluation & treatment - have you previously had evaluation of your sleep problem with:

□ Physician □ Sleep specialist □ Psychiatrist/Psychologist □ Other _____
□ Have you had a sleep study? _____ When: _____

Have you been diagnosed with sleep apnea or any other sleep disorder? _____
What type? _____ Current treatment_____
Prior treatment _____

4. Please indicate if you are experiencing any of the following sleep problems:

□ Difficulty falling asleep
□ Wake up frequently during the night
□ Prolonged awakening during the night
□ Snoring
□ Stop breathing during sleep
□ Wake up early in the morning
□ Difficulty awakening
□ Get too little sleep at night
□ Difficulty staying awake during the day

□ Restless legs

5. Do you do any of the following shortly before bedtime?

□ drink coffee or tea □ drink alcohol □ physical exercise
□ watch TV in bed □ read in bed □ read out of bed
□ work in bed □ work out of bed □ work on computer

6. Do you take any of the following medications or drugs?

□ Sleeping pills
□ Pills to stay awake/ stimulants
□ Sedatives/ tranquilizers

*Valley Medical Group is the "trading as" name for Valley Physician Services, PC, Valley Medical Services, PC and Valley Physician Services, NY, PC

7. Sleep pattern:

How long does it usually take for you to fall asleep? _____ minutes _____ hours

Usual bedtimes? Weekdays: bedtime: _____ wake time: _____
Weekends: bedtime: _____ wake time: _____

Do you work rotating shifts or night shifts? _____ Describe:_____

How much does your bedtime and wake time vary? _____

Do you frequently travel across time zones? _____

8. How many hours of sleep do you usually get during the night? _____

9. How many times do you typically wake up during the night? _____

10. If you awaken during the night, when does this occur?

□ soon after falling asleep □ in the middle of the night □ early morning

How long do you stay awake, on average? _____

What do you usually do when you awaken during the night?

□ stay in bed □ read in bed □ read out of bed □ exercise □ eat
□ watch TV □ computer □ chores □ other _____

Do you have a fear of not being able to get back to sleep? [ ] Yes [ ] No

11. Indicate the reason(s) that you wake up during the night:

□ snoring □ gasping/choking □ heartburn/reflux □ need to urinate
□ no obvious reason □ leg kicking/jerking □ dry mouth □ leg cramps
□ hunger/thirst □ heat/cold □ noise □ light
□ awakened by bed partner □ other _____

12. Do you usually (check all that apply):

□ sleep with someone else in your bed
□ sleep with pet in your bed
□ provide assistance during the night (e.g. to child, invalid)

13. How do you feel after an average night of sleep?

□ good most of the time □groggy/sleepy □poorly refreshed
□ have headache □ have jaw pain □ have dry mouth/throat

14. Do you experience sleepiness during the daytime?

□ none □ mild □ moderate □ severe

When do you feel most sleepy? □ morning □ afternoon □ evening
Do you take naps during the day? □ No □ Yes
Do you feel refreshed after a nap? □ No □ Yes

15. **Please rate how often you do the following**:

0 = never 1 = rarely 2 = sometimes 3 = frequently 4 = usually or constantly

_____ Snore _____ Snore loudly enough that others complain
_____ Stop breathing at night (observed by yourself or others)
_____ Awaken from sleep gasping for breath or choking
_____ Awaken from sleep with heartburn or belching
_____ Awaken with chest pain
_____ Awaken from sleep with cough
_____ Wake during the night for no apparent reason
_____ Sweat excessively at night
_____ Notice your heart pounding or beating irregularly during the night
_____ Fall asleep during the daytime
_____ Fall asleep involuntarily e.g. while driving
_____ Have trouble at work or school because of sleepiness
_____ Feel paralyzed/ unable to move when waking or falling asleep
_____ Experience loss of muscle tone when laughing, angry or emotional
_____ Experience vivid dream-like scenes or hallucinations upon awakening or falling asleep
_____ Have very vivid dreams or nightmares
_____ Kick, jerk or twitch repetitively during the night
_____ Experience restless legs, urge to move your legs
_____ Experience crawling, tingling or aching feeling in your legs
_____ Experience electric-like or other leg pain during the night
_____ Experience painful leg cramps during the night
_____ Walk in your sleep
_____ Eat in your sleep
_____ Talk in your sleep
_____ Acting out dreams
_____ Fall out of bed
_____ Have convulsions or seizures during sleep
_____ Wet your bed
_____ Have thoughts racing through your mind
_____ Have anxiety (or worry about things) at bedtime
_____ Experience panic
_____ Fear of not falling asleep or getting enough sleep
_____ Experience poor night sleep
_____ Grind teeth during the night
_____ Bothered by/ awakened by pain during the night
_____ Wake up feeling stiff in the mornings
_____ Experience fatigue (exhaustion) even when not sleepy

16. Does your sleep problem disturb your sex life or social life? □ No □ Yes
Describe_____

17. Personal Habits: Do you regularly drink any of the following?

_____ Alcohol Daily quantity _____
_____ Caffeinated Coffee Daily quantity _____
_____ Caffeinated Tea Daily quantity _____
_____ Caffeinate soft drinks Daily quantity _____
_____ Chocolate Daily quantity _____

18. Please indicate if you experience any of the following:

□ Headaches	□ Need antacids regularly	□ Fatigue
□ Feel panicky	□ Nightmares	□ Stomach troubles
□ Feel Tense or Anxious	□ Memory problems	□ Difficulty concentrating
□ Feel Depressed	□ Suicidal ideas	□ Feel full of anger
□ Unable to relax	□ Sexual problems	□ Palpitations
□ Alcoholism	□ Difficult home conditions	□ Fainting spells
□ Unable to have a good time	□ Inferiority feelings	□ Other_____

19. Do any other members of your family have sleep apnea or other sleep problems? Please describe.
_____
20. With whom are you now living? _____

21. Please describe any other information pertinent to your sleep or wakefulness not previously provided.

_____

22. Over the past 2 weeks, how often have you been bothered by any of the following problems?

0 = not at all 1 = several days 2 = more than half the days 3 = nearly every day

_____ Little interest or pleasure in doing things

_____ Feeling down, depressed or hopeless

The Epworth Sleepiness Scale

In the situations listed below, how likely are you to doze off or fall asleep, in contrast to just feeling tired: (This refers to your usual behavior currently.) If you have not done some of these things recently, try to determine how they might affect you.

Use the following scale to choose **the most applicable** number for each situation and enter it on the line to the right of the situation described:

0 = Would NEVER doze off
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 theater or a meeting)	_____
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 a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL SCORE:	_____

Restless Leg Syndrome (RLS) Rating Scale

Restless leg syndrome is a condition in which there is an uncomfortable, tingly or painful sensation in the legs (or arms), or a strong need to move the legs (or arms).

0 = None
1 = Mild
2 = Moderate
3 = Severe
4= Very Severe

1. Overall, how would you rate the RLS discomfort in your legs or arms? _____
2. Overall, how would you rate the need to move around because of your RLS symptoms? _____
3. Overall, how much relief of your RLS arm or leg discomfort do you get from moving around? _____
4. Overall, how severe is your sleep disturbance from your RLS symptoms? _____
5. How severe is your tiredness or sleepiness from your RLS symptoms _____
6. Overall, how severe is your RLS as a whole? _____
7. How often do you get RLS symptoms? _____
8. When you have RLS symptoms, how severe are they on an average day? _____
9. Overall, how severe is the impact of your RLS symptoms on your ability to carry out your daily affairs, for example carrying out a satisfactory family, home, social, school, or work life? _____
10. How severe is your mood disturbance from your RLS symptoms: (angry, sad, anxious, or irritable? _____

TOTAL SCORE: _____

Respiratory History:

Do you ever have shortness of breath? ___ No ___ Yes: Check all that apply:
___ At rest (sitting) # of years_____
___ After walking (level) # of years_____
___ After climbing stairs # of years_____
___ When lying on your back? # of years_____

Do you ever have wheezing? ___ No ___ Yes: When? _____

Do you have a cough? ___ No ___ Yes: Rarely _____ Occasionally _____ Often _____

When and how long have you had the cough?
□ First thing in the morning _____months _____years
□ At other times during the day or night _____months _____years
□ On most days (for as much as 3 months of the year) _____months _____years
□] At night _____months _____years
□ Cough wakes you up _____months _____years
□ At work (especially) _____months _____years

Do you cough or wheeze more in any particular season of the year? _____ Which season? _____

Do you bring up phlegm? ___ Yes ___ No
If yes, how much per day? ___ less than a teaspoon ___ # of teaspoons ___ 1/4-1/2 cup
___1/2–1 cup ___1 cup or more
What color is the phlegm? ___ White ___Yellow ___Green ____Pink ___Red

Respiratory History: Have you ever had, or been diagnosed with: (please check if yes, and enter date or number of years)

□ Asthma_____
□ Emphysema_____
□ Pleurisy_____
□ Lung surgery _____
□ Lupus_____
□ Congestive heart failure_____
□] Chronic bronchitis _____
□ Recurrent bronchitis_____
□ Post nasal drip _____
□ Thrombophlebitis (blood clot to leg/ arm)
□ Pulmonary embolism (blood clot to lung)_____
□ Pneumonia_____
□ Tuberculosis_____
□ Sarcoidosis_____
□ Hypercoagulability (thick blood)_____
□ Nasal polyps _____
□ Sleep apnea _____
□ Interstitial fibrosis _____
☐Glaucoma

History of Cigarette Smoking:

___ Never smoked
___ CURRENTLY smoke _____#packs/day _____# years smoking
___ FORMER smoker _____#packs/day _____# years smoked _____# years stopped

Allergies: Are you allergic to any of the following? Please specify:

□ Medications (antibiotics, others): _____
□ Environmental (e.g., pollen, mold, dust, animals): _____
□ X-ray dye/ Iodine_____
□ Shellfish/seafood_____
□ Latex
□ Eggs

□ Pets
□ Other _____

Occupational History- Exposure: Current work: _____

Have you ever done any of the following types of work or had exposure to the following?

□ Construction: Type: _____
□ Work with asbestos
□ Elevator installation
□ Mining
□ Brick/masonry work
□ Prolonged exposure to birds
□ Insulation work
□ Auto brake-lining
□ Plumbing
□ Quarry work, foundry work, or sandblasting
□ Farm Work
□ Navy yard, shipyard work
□ Prolonged exposure to animals or pets
□ Millwork such as in a cotton, flax, or hemp mill: Which type? _____
□ Exposure to chemicals or fumes: Which types? _____
□ Manufacturing glass, ceramics or abrasives
□ Work with solvents, plastics, acids, lead, TDI or PVC? Specify_____
□ Other chemical/fumes/silica exposure? Specify_____

Date of last Chest X-Ray _____ **Date of last CT scan of lungs**_____

Date of last skin test for TB: _____

Other Medical Problems: Have you EVER had any of the following medical problems?
List date, number of years:

□ High blood pressure _____
□ Heart disease _____
□ Rheumatic fever_____
□ Ulcers _____
□ Stroke _____
□ Bleeding problems_____
□ Blood Clot_____
□ Cancer: _____Type:_____
□ Severe Allergic Reaction _____
□ Diabetes_____
□ Heart Attack _____
□ Abnormal heart rhythm _____
□ Liver problems _____
□ Anemia _____
□ Kidney problems_____
□ Thyroid problems_____
□ Gastric reflux _____
□ Rheumatoid arthritis _____

Other Symptoms: Have you EVER had any of the following symptoms or problems?

□ Poor appetite
□ Excessive sleepiness
□ Swelling of legs/ankles
□ Night sweats/chills
□ Weight gain _____lbs.
□ Weight loss _____lbs.
□ Excessive snoring
□ Joint pain
□ Excessive appetite
□ Chest pain
□ Recent fever
□ Muscle/bone pains

Medications:
Please list the names of all prescription and over the counter medications you are currently taking:

Name	Dose	# times/day	How long taking it

_____ _____ _____ _____
_____ _____ _____ _____

Please use additional sheets of paper if necessary to list all medications.

Hospitalizations/ Surgeries: Please list all prior hospitalizations and surgeries.

Year	Reason	Year	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History: Check all family members who have/ had the following diseases:

	Mother	**Father**	**Sister**	**Brother**	**Grand mother Maternal**	**Grand mother Paternal**	**Grand father Maternal**	**Grand Father Paternal**	**Other**
Deceased?	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Asthma									
Emphysema									
Chronic bronchitis									
Bronchiectasis									
Interstitial fibrosis									
Sleep apnea									
Narcolepsy									
Insomnia									
Restless legs									
Cancer									
Diabetes									
Heart disease									
High blood pressure									
Stroke									
Other									