SLEEP & LUNGS: SLEEP MEDICINE
NEW PATIENT QUESTIONNAIRE

Name:_____
DOB:_____

Date: _____ Sex: _____ Age: _____Height: _____

Referring physician: _____
Primary care physician: _____

What is your primary sleep problem?_____
Please explain any strange feelings or behavior you have or had during the night.
_____
Who initially suspected a sleep problem?_____
Do you currently have a bed partner/roommate? _____ Yes _____ No If yes, please have them assist you with this questionnaire.
Have you been seen by a sleep specialist before? _____
On weekdays I sleep _____ hours, mostly from _____ to _____.
On weekends I sleep _____ hours, mostly from _____ to _____.
In what position(s) do you normally sleep? _____
Do you take frequent naps during the day? _____ Yes _____ No
If yes, how many days a week? _____
How long is the nap? _____
What time of day is the nap? _____
Are they refreshing? _____ Yes _____ No
Have you ever fallen asleep while driving? _____ Yes _____ No
If yes, did a motor vehicle accident occur? _____ Yes _____ No
On scale of 1 to 10 where 1 is very bad and 10 is very good, how would you rate your sleep overall? _____

Sleep/Social History

How many caffeinated drinks do you have daily? _____
What time is the last caffeinated drink of the day? _____
Do you exercise regularly? _____ Yes _____ No
Have you ever used diet pills? _____ Yes _____ No
Have you ever used stimulant drugs before? _____ Yes _____ No
Do you currently smoke cigarettes? _____ Yes _____ No
Have you ever smoked cigarettes? _____ Yes _____ No
How many packs per day? _____
How many years did you smoke? _____
Have you quit smoking yet? _____ Yes _____ No
How much alcohol do you consume within three hours of bedtime? _____
How much alcohol do you consume within a 24-hour period? _____
Do you or have you ever used recreational drugs? _____ Yes _____ No
If yes, what type of drug? _____
What is your occupation? _____
Level of education? (circle one) High School College Graduate/Professional
Marital Status (circle one) Single Married Separated Divorced Widowed
Do you live alone? _____ Yes _____ No
If no, with whom do you live? _____
Have you recently traveled? _____ Yes _____ No
If yes, where? _____
Have you ever served in the military? _____ Yes _____ No
If yes, did you see combat? _____ Yes _____ No

Family History:
Please provide any medical problems and sleep issues for the following

Mother _____
Father _____
Siblings _____
Children _____

Allergies: Please list any medication allergies or drug reactions you have or have had.
Drug:_____Reaction:_____
Drug:_____Reaction:_____

Medications:Please list any medication you are currently taking with the dose and how often they are taken. Include over-the-counter sleeping pills such as Melatonin and include as well any herbal remedies and vitamins/supplements. If you have provided a list to the front desk you may skip this question.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Medical History: Have you now or in the past experienced any health problems in the following areas?

_____ High blood pressure
_____ Deviated nasal septum
_____ Sinus problems
_____ Tonsillectomy
_____ Heart Disease
_____ Psychiatric (depression, anxiety)
_____ Stroke / TIA
_____ Fibromyalgia
_____ Shortness of breath
_____ Chronic cough
_____ Asthma
_____ Emphysema
_____ Thyroid Disease
_____ Diabetes
_____ Heartburn / Reflux
_____ Chronic pain

Please list any other medical problems you have or have had:
_____
_____

Please list any surgeries you have had:

Procedure	Date
_____	_____
_____	_____
_____	_____

Do you have any specific questions you wish to ask your sleep clinician?
_____
_____
_____
_____

Name:_____
DOB:_____

Are you currently having any of the following problems? Circle Yes or No.

Constitution
(fever, chills, weight loss/gain) Yes No

Eyes
(blurred/double vision, floaters, eye pain) Yes No

Ears, Nose, Throat
(hearing loss, ringing, congestion, imbalance difficulty swallowing) Yes No

Cardiovascular
(chest pain, irregular beats, swelling in legs) Yes No

Respiratory
(coughing, wheezing, short of breath) Yes No

Gastrointestinal
(nausea, vomiting, heartburn, constipation, diarrhea, stomach pain, blood in stool) Yes No

Endocrine
(excessive thirst, sweating, too hot/cold) Yes No

Genitourinary
(overnight urination, incontinence, painful urination, urinary frequency, bleeding with urination, decrease sex drive, impotence menstrual problems) *Yes* No

Musculoskeletal
(pain in muscles/joints, swelling, Weakness, leg movements before/during sleep, recent falls) Yes No

Skin
(rash/hives, pain, itching) Yes No

Neurologic
(numbness/tingling, headache, dizziness, seizure, loss of consciousness) Yes No

Psychological
(mood problems, depression, anxiety, increase life stressors, crying spells, thoughts of suicide) Yes No

Lymph/Heme
(seasonal allergies, food allergies bleeding/bruising problems) Yes No

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How sleepy have you been over the last 4 weeks?

Situation	Chance of Dozing or Sleeping Low (circle the most appropriate number) High			
Sitting and reading ……	0	1	2	3
Watching TV……	0	1	2	3
Sitting inactive in a public place……	0	1	2	3
Being a passenger in a motor vehicle for an hour or more..	0	1	2	3
Lying down in the afternoon……	0	1	2	3
Sitting and talking to someone……	0	1	2	3
Sitting quietly after lunch (no alcohol)……	0	1	2	3
Stopped for a few minutes in traffic while driving……	0	1	2	3

Total Score (add up the circled numbers)…….

Name:_____
DOB:_____

Sleep Questions: Please respond to what extent a statement (item) has been applicable to you during the past 4 weeks. Score each item on a 4-point-scale:

1 (not at all) 2 (somewhat) 3 (rather much) 4 (very much)

Section 1: ____

1. I am told that I snore.	1 2 3 4
2. I sweat during the night.	1 2 3 4
3. I am told that I hold my breath when sleeping.	1 2 3 4
4. I am told that I wake up gasping for air.	1 2 3 4
5. I wake up with a dry mouth.	1 2 3 4
6. I wake up during the night while coughing or being short of breath.	1 2 3 4
7. I wake up with a sour taste in my mouth.	1 2 3 4
8. I wake up with a headache.	1 2 3 4

Section 2: ____

9. I have difficulty in falling asleep.	1 2 3 4
10. Thoughts go through my head and keep me awake.	1 2 3 4
11. I worry and find it hard to relax.	1 2 3 4
12. I wake up during the night.	1 2 3 4
13. After waking up during the night, I fall asleep slowly.	1 2 3 4
14. I wake up early and cannot get back to sleep.	1 2 3 4
15. I sleep lightly.	1 2 3 4
16. I sleep too little.	1 2 3 4

Section 3: ____

17. I see dreamlike images when falling asleep or waking up.	1 2 3 4
18. I sometimes fall asleep on a social occasion.	1 2 3 4
19. I have sleep attacks during the day.	1 2 3 4
20. With intense emotions, my muscles sometimes collapse during the day.	1 2 3 4
21. I sometimes cannot move when falling asleep or waking up.	1 2 3 4

Section 4: ____

22. I am told that I kick my legs when I sleep.	1 2 3 4
23. I have cramps or pain in my legs during the night.	1 2 3 4
24. I feel little shocks in my legs during the night.	1 2 3 4
25. I cannot keep my legs at rest when falling asleep.	1 2 3 4

Name:_____

DOB:_____

Section 5: _____

26. I would rather go to bed at a different time.	1 2 3 4
27. I go to bed at very different times (more than 2 hr difference).	1 2 3 4
28. I do shift work.	1 2 3 4

Section 6: _____

29. I sometimes walk when I am sleeping.	1 2 3 4
30. I sometimes wake up in a different place than where I fell asleep.	1 2 3 4
31. I sometimes find evidence of having performed an action during the night I do not remember.	1 2 3 4

Section 7: _____

32. I have frightening dreams (if not, go to Item 37).	1 2 3 4
33. I wake up from these dreams.	1 2 3 4
34. I remember the content of these dreams.	1 2 3 4
35. I can orientate quickly after these dreams.	1 2 3 4
36. I have physical symptoms during or after these dreams (e.g., movements, sweating, heart palpitations, shortness of breath).	1 2 3 4

Section 8: _____

37. It is too light in my bedroom during the night.	1 2 3 4
38. It is too noisy in my bedroom during the night.	1 2 3 4
39. I drink alcoholic beverages during the evening.	1 2 3 4
40. I smoke during the evening.	1 2 3 4
41. I use other substances during the evening (e.g., sleep or other medication).	1 2 3 4
42. I feel sad.	1 2 3 4
43. I have no pleasure or interest in daily occupations.	1 2 3 4

Section 9: _____

44. I feel tired at getting up.	1 2 3 4
45. I feel sleepy during the day and struggle to remain alert.	1 2 3 4
46. I would like to have more energy during the day.	1 2 3 4
47. I am told that I am easily irritated.	1 2 3 4
48. I have difficulty in concentrating at work or school.	1 2 3 4
49. I worry whether I sleep enough.	1 2 3 4
50. Generally, I sleep badly.	1 2 3 4

Name:_____
DOB:_____