**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

# Watermark Medical ARES Questionnaire ©

PRINT IN CAPITAL LETTERS - STAY WITHIN THE BOX All Fields Required-unless otherwise specified

Last Name | First Name | Middle Initial | Gender: Male ☐ Female ☐

**Date of Birth** (Month / Day / Year) | **Weight** (Pounds) | **Height** (Feet / Inches) | **Neck Size** (Inches)

**I.D. Number** (optional)

Tally ARES Risk Points

Neck Size +2 Male ≥16.5 +2 Female ≥15

Score ☐

***COMPLETELY FILL IN ONE SQUARE FOR EACH QUESTION - ANSWER ALL QUESTIONS***

**Have you been diagnosed or treated for any of the following conditions?**

| | | | | | |
|---|---|---|---|---|---|
| High blood pressure | Yes ☐ | No ☐ | Stroke | Yes ☐ | No ☐ |
| Heart disease | Yes ☐ | No ☐ | Depression | Yes ☐ | No ☐ |
| Diabetes | Yes ☐ | No ☐ | Sleep Apnea | Yes ☐ | No ☐ |
| Lung disease | Yes ☐ | No ☐ | Nasal oxygen use | Yes ☐ | No ☐ |
| Insomnia | Yes ☐ | No ☐ | Restless legs syndrome | Yes ☐ | No ☐ |
| Narcolepsy | Yes ☐ | No ☐ | Morning Headaches | Yes ☐ | No ☐ |
| Sleep Medication | Yes ☐ | No ☐ | Pain Medication e.g. vicodin, oxycontin | Yes ☐ | No ☐ |

Co-morbidities +1 for each Yes response

Score ☐

Do not assign any points for these eight responses

**Epworth Sleepiness Scale:** How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale tomark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze 1 = slight chance of dozing
2 = moderate chance of dozing 3 = high chance of dozing

| | 0 | 1 | 2 | 3 |
|---|---|---|---|---|
| Sitting and reading | ☐ | ☐ | ☐ | ☐ |
| Watching TV | ☐ | ☐ | ☐ | ☐ |
| Sitting, inactive, in a public place (theater, meeting, etc) | ☐ | ☐ | ☐ | ☐ |
| 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 | ☐ | ☐ | ☐ | ☐ |

Epworth Score Total the values from all 8 questions. If 11 or less Score = 0 If 12 or more Score = 2

Score ☐

**Frequency** (Check one for each question): Never **+0**, Rarely **+1** times/wk, Sometimes **+2** times/wk, Frequently **+3** times/wk, Almost Always **+4** times/wk.

On average in the past month, how often have you snored or been told that you snored?

Never +0 ☐ Rarely +1 ☐ Sometimes +2 ☐ Frequently +3 ☐ Almost always +4 ☐

Do you wake up choking or gasping?

Never +0 ☐ Rarely +1 ☐ Sometimes +2 ☐ Frequently +3 ☐ Almost always +4 ☐

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

Never +0 ☐ Rarely +1 ☐ Sometimes +2 ☐ Frequently +3 ☐ Almost always +4 ☐

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always ☐

Total points for the first three responses ☐

Point Total ☐

I have personally completed this questionnaire.
Signature

Date

Phone Number

Total all 4 boxes from the right side

If points total =3 or lower (no risk) 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)