CHI Memorial

CHI Memorial Regional Sleep Center **Patient Questionnaire**

Name:_____Date:_____
DOB:_____Height:_____Weight:_____
Emergency Contact Name/Phone #: _____
Next of Kin Name/Phone #: _____
Insurance Name & Policy #: _____

Primary Care Physician: _____ Phone #: _____
Name of Referring Physician: _____ Phone #: _____

Have you ever seen any other physician for your sleep problem?
( )NO ( )YES - please provide the Date, Sleep Center Name, and Address of any Sleep Studies
_____
_____
_____
How would you describe your sleep problem? _____
Check all that apply ( )Snoring/Witnessed apnea ( )Difficulty falling asleep ( )Daytime Sleepiness
( )Difficulty Waking ( )Unwanted Behaviors During Sleep ( )Waking up during the night
( ) Other_____
How many nights per week do you have a sleeping problem?_____
How long have you had this problem? _____
Please estimate the severity of this problem ( )Mild ( )Moderate ( )Extreme
Please describe your sleep problem, including when and how it began:
_____
_____
_____
_____

PERSONAL HABITS:
Tobacco: Do you presently smoke? ( ) yes ( ) no # cigarettes/day _____ How many years_____
Did you ever smoke? ( ) yes ( ) no # cigarettes/day _____ How many years_____
When did you quit smoking? _____
Alcohol: Do you drink Alcohol? ( ) yes ( ) no # Drinks/Day_____
Did you every drink alcohol? ( ) yes ( ) no # Drinks/Day _____ When did you quit?_____
Recreational Drug Use: Have you in the past or do you currently use recreational drugs? ( ) yes ( ) no
If so, what did you use and when did you last use recreational drugs? _____
Caffeine: Do you drink or consume caffeinated products (coffee, tea, soda, or chocolate)? ( )yes ( )no
What products and quantity do you consume daily?_____

FAMILY HISTORY: Married ( )yes ( )no Children: ( )yes ( )no Age(s) of Children _____

	Mother	Father	Brother(s)	Sister(s)	Grandparent(s)
High Blood Pressure	_____	_____	_____	_____	_____
Coronary Disease	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____

Cancer (Type)	_____	_____	_____	_____	_____
Obstructive Sleep Apnea	_____	_____	_____	_____	_____
Restless Legs	_____	_____	_____	_____	_____
Insomnia	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

PAST MEDICAL HISTORY:

___Gastric Reflux ___Restless Legs ___Atherosclerotic heart disease or heart attack

___Fibromyalgia ___Emphysema/COPD ___Cardiac Arrhythmia (irregular heart rate)

___Hypothyroidism ___Asthma ___Hypertension

___Enlarged prostrate ___Hay Fever/Allergy ___Stroke

___Depression ___Pulmonary Hypertension ___Diabetes

___Seizures ___Other Lung Disease ___Congestive Heart Failure

___Epilepsy ___Cancer/Type _____ ___High Cholesterol/Triglycerides

___Memory Issues ___Angina ___Edema (water retention)

REVIEW OF SYMPTOMS:

- Have you **gained** ___No ___Yes or **lost** ___No ___Yes WEIGHT in the past 12 months? How much? _____
- Do you regularly have a problem breathing through your nose? ___No ___Yes
- If you are male, have you had problems with impotency? ___No ___Yes How long? _____
- Do you become short of breath with physical exertion (walking/exercise)? _____No _____Yes
- Do you have chronic cough? _____No _____Yes
- Do you have excessive phlegm or sputum? _____No _____Yes
- Do you have episodes of wheezing or chest tightness? _____No _____Yes
- Do you have swelling of your ankles or feet? _____No _____Yes
- Do you have difficulty swallowing food, indigestion, heartburn or regurgitation of acid back into your chest or mouth (Reflux) _____No _____Yes _____
- Have you had any change in your usual bowel habits recently, such as constipation, change in shape, color etc.? _____No _____Yes - _____
- Have you had any difficulty when urinating such as burning, blood in urine, or poor urine stream? _____No _____Yes -_____
- Have you experienced any neurologic problems such as:
    1. Persistent loss of sensation ___No ___Yes - _____
    2. Loss of muscle strength ___No ___Yes - _____
    3. Poor coordination, clumsiness balance difficulty ___No ___Yes - _____

4. Memory loss? ___No ___Yes -

_____

_____

- Do you have any persistent arthritis, joint pains, or other musculoskeletal discomfort? ___No ___Yes

_____

- Do you have excessively dry skin? ___No ___Yes - _____
- Do you have a strong preference for a **cool** ___No ___Yes or **warm** ___No ___Yes environment?

_____

- Describe any other persistent symptom(s) important to you:

_____

_____

_____

MEDICATIONS

Please list all the current medications, vitamins, herbal supplements, and oxygen you currently take and the doses

_____

_____

_____

ALLERGIES: If none, please state so, otherwise list them.

Name Reaction

_____ _____

_____ _____

_____ _____

OPERATIONS: **YEAR:**

_____ _____

_____ _____

_____ _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 to choose the most appropriate number for each situation:

EPWORTH SLEEPINESS SCALE (ESS)

Situation	Chance of dozing (0–3)			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place — for example, a theater or meeting	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
In a car while stopped in traffic	0	1	2	3
Total Score				

0 = Would never doze 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

Reference: Johns MW. A new method for measuring daytime sleepiness: the Epworth sleepiness scale. Sleep. 1991 Dec;14(6):540-5.