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)	__________	__________	__________	__________	___________
Thyroid Disease	__________	__________	__________	__________	___________
Obstructive Sleep Apnea	__________	__________	__________	__________	___________
Restless Legs	__________	__________	__________	__________	___________
Insomnia	__________	__________	__________	__________	___________
Other	__________	__________	__________	__________	___________

SLEEP SCHEDULE ENVIRONMENT, AND HYGIENE

On weekdays I sleep __________ hours, mostly from ____________ to ____________. Do you work? ____________________

On weekends I sleep __________ hours, mostly from ____________ to ____________. Work Hours: _____________________

Do you take frequent naps during the day? ___________Yes ____________ No

What time of day is the nap? ____________________ Are they refreshing? ______________Yes ______________ No

On a scale of 1 to 10 where 1 is very bad and 10 is very good, how would you rate your sleep overall? ________________

Please check ALL that apply to you:

___Headaches in the morning
___Sore throat or dry mouth on awakening
___Sudden muscle weakness when laughing, angered or surprised
___Have you been told of any abnormal behaviors during sleep
___Have you awakened short of breath or gasping for air
___Do you stop breathing during your sleep
___Difficulty waking in the morning
___Do not feel tired at bedtime
___Do you function best in the evening
___Do you have jaw pain in the morning
___Has daytime sleepiness affected your job or school performances
___Do you sweat during sleep
___Do you sleep better in unfamiliar settings
___Do you have nightmares
___Do you drink caffeine within 2 hours of bedtime
___Have you ever had sudden attacks of sleeping
___Do you watch TV in the bedroom before falling asleep
___Have you had increased irritability or trouble thinking
___Do you fall asleep easily while riding as a passenger
___Have you ever fallen asleep while driving or when stopped
___Do you have loud snoring
___Your snoring is worse on your back
___Do you have family who snore
___Do you feel very sleep during the day
___Does your bed partner disturb your sleep
___Do you feel refreshed on waking
___Do you ever have chest pain or palpitations
___Do you have cramping in your legs at night
___Does movement help the legs feel better
___Restless legs are worse at night
___You have restless feeling in your legs
___Do you do physical activity before bed
___Your bedroom is quiet and dark
___Do you sleep with pets
___Do you worry excessively in bed
___Have you been told you talk in your sleep
___Have you been told you walk in your sleep
___Do you grind your teeth at night
___Do you read before falling asleep

SNORING AND SLEEP APNEA **PLEASE DESCRIBE:**

How often do you snore? ____

How many years have you been snoring? ____

If so, how severe is your snoring? ____

Has your snoring become progressively worse? ____

Have you every awakened because of your snoring? ____

In what positions do you snore? (please check all that apply) ( )back ( )side ( )stomach ( )sitting

Which best describes your pattern of snoring? ( ) continuously ( ) occasionally ( ) rarely

( ) I snore, stop breathing, and then snore again

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.