Premier Sleep Center **SLEEP QUESTIONNAIRE**

Printed Patient Name:_____ **Date of Birth:** _____

REASON FOR VISIT: _____ **Today's Date:** _____

Referring Physician: _____ Primary Care Physician: _____

Height: _____feet _____inches Weight: _____

Emergency Contact: _____ Relationship: _____
Contact Number: _____

Date of Last Complete Physical Exam: _____

MEDICATION ALLERGIES: _____ **No Known Allergies** If yes, complete below:

Drug Name	Reaction

ENVIRONMENTAL ALLERGIES: (Mark all that apply)

_____ Do you have seasonal allergies? ____ Spring ____ Summer ____ Fall ____ Winter
_____ Have you ever had skin testing for allergies? When_____
_____ Are you exposed to animals and does this exposure cause symptoms?
_____ Cats Symptoms:_____
_____ Dogs Symptoms:_____
_____ Birds Symptoms:_____
_____ Rodents Symptoms:_____

CURRENT MEDICATIONS: (Include **INHALERS** and **OXYGEN)**

NAME	DOSE	FREQUENCY	INDICATION

SLEEP MEDICATIONS:

NAME	DOSE	FREQUENCY	INDICATION

Patient Name: _____

SLEEP HISTORY:

QUESTION	NEVER	RARELY	SOMETIMES	FREQUENTLY
You have trouble getting to sleep at night.				
You are bothered by frequent awakenings.				
How often during the night do you wake up?				
You bothered by long periods of wakefulness during the night.				
You bothered by waking up too early and not being able to get back to sleep.				
You have nightmares.				
You awaken from sleep short of breath.				
You snore loudly enough that your spouse or others complain about it.				
How often do you have a problem sleeping?				
You feel tired during the day.				
You take naps?				
You feel confused when you awaken from sleep.				
You feel refreshed after a short (10-15 minute) nap?				
Your sleepiness appears to be worse three to four times per day.				
Your sleepiness occurs at fairly predictable intervals.				
You awaken in the morning with headaches?				
Other people tell you that you have a restless sleep.				
Others noticed that you have become increasingly irritable or short-tempered.				
Your sexual activity has decreased.				
Your mind is not working as quickly or effectively as it used to				
You perspire a great deal at night.				
When you are angry or laugh you feel weak; You feel as though you might fall.				
Your ankles swell and you have trouble getting your shoes on and off.				

Smoking History (Mark and Complete all that apply)

Never Smoked		
Quit Smoking When -		Average Packs / Day
		Number of Years Smoked
Currently Smoking		Average Packs / Day
		Number of Years Smoked

Patient Name: _____

SITUATION: HOW LIKELY ARE YOU TO FALL ASLEEP IN THE FOLLOWING SITUATIONS (Use the scale on the right):

Scale: **0** – Would Never Dose
1 - Slight Chance of Dosing
2 – Moderate Chance of Dosing
3 – High Chance of Dosing

SITUATION	RANK
Sitting and Reading	0 1 2 3
Watching Television	0 1 2 3
Sitting Inactive in a Public Place (ie. Theater, waiting room, 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 when circumstances permit	0 1 2 3
Sitting and talking with someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car while stopped for a few minutes in traffic	0 1 2 3

ANSWER THE FOLLOWING QUESTIONS:

QUESTION	RESPONSE
Have you ever had a sleep study?	
If yes, what were the results?	
Are you currently using CPAP machine?	
Are you currently using an oral appliance?	
On average, how many minutes does it take you to fall asleep?	
If you are bothered by long periods of wakefulness during the night, how many minutes do you spend awake each night?	
How many hours do you actually sleep at night?	
How long have you been experiencing sleeping problems?	
Are your sleep habits on your days off different than they are during your work week?	
What time do you usually go to bed during your days off?	
What time do you usually go to bed during your work week?	
Describe how you feel when you wake up in the morning.	

LIST ANY OTHER HEALTH PROBLEMS YOU HAVE:

_____ _____

_____ _____

DO OTHER MEMBERS OF YOUR FAMILY HAVE SLEEPING PROBLEMS? YES NO

Patient Name: _____

REVIEW OF SYMPTOMS: (Mark All that Apply)

General	**Cardiovascular**	**Genitourinary**
Weight Changes	Chest Pain	Pain with Urination
Sleeping Problems	Heart Attack	Frequent Urination
Loud Snoring	Heart Murmur	Blood in Urine
Fevers/Chills/Sweats	Palpitations	Kidney Stones
Skin	Irregular Heart Beat	**Musculoskeletal**
Skin Rash	Shortness of Breath w/Walking	Joint Pain/Swelling
Itching	Dizziness	Back Pain
New Skin Marks/Spots	Swelling of Feet/Ankles	Muscle Pains/Aches
Head/Eyes/Ears/Nose/Throat	**Gastrointestinal**	**Neurological**
Visual Problems/Changes	Nausea / Vomiting	Numbness
Itching Eyes/Nose	Vomiting Blood	Tingling
Nose Bleeds	Difficulty Swallowing	Weakness/Paralysis
Drainage From Nose	Heartburn/Indigestion	Tremors
Sinus Infections	Abdominal Pain	Seizures
Hoarseness	Constipation	**Psychological**
Sore Throats	Diarrhea	Depression
Headaches	Bloody/Black Stools	Anxiety/Panic Attacks
Respiratory	**Endocrine**	
Coughing	Diabetes	Thyroid Hyper Hypo
Wheezing	**Other Medical Problems Not Listed**	
Shortness of Breath		
Bronchitis		
Frequent Colds		
Coughing Up Blood		

Patient Signature: _____ Date: _____