SAINT LUKE'S MIDWEST PULMONARY CONSULTANTS

PATIENT QUESTIONNAIRE

NAME _____ AGE_____ DATE OF BIRTH _____
(include middle initial)

DATE OF APPOINTMENT _____

Briefly describe your main sleep problem:

Do you have any other complaints about sleep? If yes, please describe.

If you **currently** take any medications for sleep, please list the name and what time you take it.

_____ _____
_____ _____
_____ _____
_____ _____

If you have taken any over the counter or prescription medications for sleep **in the past**, please list them:

_____ _____
_____ _____
_____ _____
_____ _____

For questions below, please circle answers and fill in blanks.

Do you have a regular bed partner? yes no
How do you feel as bedtime approaches? (please circle)
Looking forward to sleep Calm Anxiety Angry Worried

Do you smoke a cigarette just before going to sleep? yes no occasionally
Do you have caffeine within four hours of bedtime? yes no occasionally
Do you drink alcohol within two hours of bedtime? yes no occasionally
Do you exercise within four hours of bedtime? yes no occasionally

What time do you usually get into bed? Weekdays _____ Weekends _____
Do you try to fall asleep right away? yes no
If no, what do you usually do in bed before sleep? please circle all that apply:
Read Watch television Listen to music Use computer Talk on phone
Other_____
Is your bedroom dark and quiet? yes no
If no, please describe_____

For questions below, please circle answers and fill in blanks.

How long does it take you to fall asleep?_____ minutes _____ hours
How many times do you wake up during the night?_____

What do you do during awakenings? Please circle all that apply.

Change position Look at the clock Read Get out of bed Go to the bathroom
Watch television Eat Drink water Smoke a cigarette
Other_____

After an awakening how long does it take you to get back to sleep?_____

What time do you usually get up in the morning? Weekdays _____ Weekends _____

Do you use an alarm: yes no If yes, for what time is it set?_____

How many hours of sleep do you get each night? Weekdays_____ Weekends_____

How do you sleep away from home? Same Better Worse

Do you:

Feel refreshed when you get up in the morning? yes no

Feel sleepy during the day? yes no

If yes, how long ago did this start? _____

Doze or fall asleep when you do not intend to? yes no

If yes, what are you doing when you doze? (circle all that apply)

Inactive Reading Watching television Working at the computer During meetings
At the movies/theater Talking to someone Other_____

Feel drowsy while driving? yes no

If yes, have you ever fallen asleep while driving? yes no

Take deliberate naps? yes no

If yes, what is the usual time of your naps and how long do you sleep?

Time _____ Length _____

How many naps do you take weekly? _____

Do you snore? yes no occasionally do not know

Does your snoring disturb others? yes no do not know

Do you wake yourself with your snore? yes no

Have you awakened with a gasp, feeling short of breath or choking? yes no

Has anyone observed pauses in your breathing while you were sleeping? yes no

Do you have dry mouth in the morning? yes no

Do you awaken with a headache? yes no

Do have a preferred sleep position? yes no Back Stomach Side

For questions below, please circle answers and fill in blanks.

Have you ever:

Had sudden bouts of muscle weakness caused by laughter or strong emotion? yes no

Felt unable to move while falling asleep or waking up? yes no

Felt you were dreaming while awake? yes no

Had any of the following behaviors during sleep? Please circle all that apply.

Talking Walking Yelling out Appear to act out your dreams

If yes, what part of the night do they occur?

First half Second half Anytime Varies

Do you have uncomfortable feelings in your legs while inactive? yes no

If yes, please circle the words that best describe these feelings:

Creeping Crawling Itching Tingling Aching Tension Difficult to describe

Other_____

Do the feelings cause you an urge to move your legs? yes no

Does movement decrease or stop these feelings? yes no

What time of the day do the feelings usually start? _____

Do the feelings occur **only** when you are inactive? yes no

Are the feelings worse in the evening? yes no

Are the feelings worse in bed? yes no

Do the feelings interfere with your sleep? yes no

Has anyone ever told you that your legs move while you are asleep? yes no

Have you had any of the following medical problems? (please circle answer for each)

High blood pressure	yes	no	Seizures	yes	no	
Heart attack	yes	no	Neuropathy	yes	no	
Atrial fibrillation	yes	no	Dementia	yes	no	
Heart valve disease	yes	no	Anemia	yes	no	
Alzheimer's disease	yes	no	Iron dificiency	yes	no	
High cholesterol	yes	no	Kidney disease	yes	no	
Asthma	yes	no	Cancer	yes	no	Type:_____
Emphysema	yes	no	Diabetes	yes	no	
Deviated septum	yes	no	Thyroid disease	yes	no	
Bronchitis	yes	no	Depression	yes	no	
Reflux	yes	no	Bipolar disorder	yes	no	
Fibromyalgia	yes	no	Anxiety	yes	no	
Arthritis	yes	no	Other_____			
Heartburn	yes	no	Other_____			
Stroke	yes	no				

Have you had a tonsillectomy? yes no

Please list any other surgeries or hospitalizations and when:

_____

_____

_____

_____

_____

_____

For questions below, please circle answers and fill in blanks.

Do you have any medication allergies or serious side effects? yes no

If yes, please list the medication and the reaction it causes:

_____
_____
_____
_____

Do you have any other allergies? (food, pollen, dust, animals, etc) yes no

If yes, please list and the reaction it causes:

_____
_____
_____
_____

Please list all medications you take, including over the counter medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Personal/Social history:

Occupation: _____

Education: _____

Other household members:

none husband wife partner mother father children roommate

Number of children: sons_____ daughters_____

Caffeine: How much of these caffeinated beverages do you drink?

Coffee_____ Tea_____ Soda_____ Energy Drink_____

Alcohol: How much of these alcoholic beverages do you drink?

Beer_____ Wine_____ Liquor_____

Cigarettes: never quit (when: _____) current smoker

How many packs per day? _____ How many years: _____

For questions below, please circle answers and fill in blanks.

Family history:

Any family members with the following sleep disorders? Yes No If yes, list family members:

Obstructive sleep apnea _____ Restless legs syndrome _____

Snoring _____ Narcolepsy _____

Insomnia _____ Behaviors during sleep _____

Other pertinent family history:

Mother: alive deceased age_____ medical problems_____

_____

Father: alive deceased age_____ medical problems_____

_____

Sibling's medical problems: _____

_____

Children's medical problems: _____

_____

Current weight: _____ pounds; weight 5 years ago: _____ pounds; weight ten years ago: _____ pounds

If you currently have any of the following, please check:

fatigue____
weight loss____
weight gain____
rashes____
dry eyes____
glaucoma____
wear glasses____
hearing loss____
wear hearing aid____
ear pain____
ringing in the ears____
vertigo____
stuffy nose____
runny nose____
postnasal drip____
nosebleeds____
sinus pain/congestion____
frequent colds____
sinus infections____
seasonal allergies____
dry mouth____
dry throat____
hoarseness____
frequent sore throat____
wheezing____
coughing____

shortness of breath____
chest pain____
fainting____
heart attack____
palpitations____
difficulty breathing lying flat___
leg or ankle swelling____
heartburn____
reflux____
bloating____
hiatal hernia____
diarrhea____
constipation____
regular menstrual periods____
menopause____ (when____)
erectile dysfunction____
frequent urination during day_____
frequent urination during night____
incontinence____
blood in urine____
neck pain____
back pain____
sciatica____
joint stiffness____
joint pain____
muscle soreness____

leg cramps____
numbness____
headache____
memory loss____
weakness____
tremors____
confusion____
poor balance____
use a cane/walker____
wheelchair____
bruise easily____
bleeding problems____
received blood transfusion____
heat intolerance____
cold intolerance____
excessive sweating____
excessive thirst____
depression____
anxiety____
irritability____
difficulty concentrating____
nervousness____
mood changes____

other_____
other_____