Pinehurst Medical Clinic Sleep Medicine Questionnaire

Name:_____Date: _____

Referring Doctor: _____

Primary Doctor:_____

What issues are you having that require you to see a sleep specialist:_____

_____

Please help us find out about you by filling out the "Patient" side of this form

PATIENT CLINICIAN

When did your sleep issues begin? _____

Any trouble sleeping as a child or teenager? ☐ Yes ☐ No

If you have tried any sleep medications which ones?

_____ _____ _____

_____ _____ _____

Are you currently using a sleep aid and which one? _____

Tell us about your sleep schedule:

What is your weekday bedtime? _____ wake up? _____

weekend bedtime? _____ wake up? _____

How long does it take for you to fall asleep?_____minutes_____hrs.

What time do you eat dinner? _____

What snacks/drinks do you typically consume after dinner?

_____

What do you do after dinner? _____

_____

Do you do any of the following activities **in bed before bedtime**?

Circle all that apply: Read Watch TV Play Video Games

Talk on the Phone Use Cell Phone, Tablet, or Computer

How many times do you wake up in the middle of the night? _____

able to fall back to sleep easily? ☐Yes ☐ No ☐ Not always

How often do you need to get up to urinate during sleep? _____

What do you do when you are unable to sleep? _____

_____

.....

Are you currently working? ☐ Yes ☐ No

If yes, what are your hours? _____

Do you work weekends? ☐ Yes ☐ No Shift Work? 1st 2nd 3rd

Retired? ☐ Yes ☐ No

Disabled? ☐ Yes ☐ No

BMI>35

Age>50

Neck:

Gender:

Mallampati:

PATIENT	CLINICIAN

Do you take daytime naps? ☐ Yes ☐ No
How many per week? _____
How long do they last? _____
What time of the day? _____
Are the naps refreshing? ☐ Yes ☐ No
Do you doze (unintentional falling asleep) in the afternoon or evening?
☐ Yes ☐ No

Do you ever experience restlessness in your legs before bedtime?
☐ No ☐ Yes: how many days per week? _____
If yes, does it disrupt your sleep? ☐ Yes ☐ No
Do you move or kick your legs while sleeping? *(Bed partner complains*)
☐ Yes ☐ No ☐ Don't know

Never smoked ☐
Currently smoking? ☐ No ☐ Quit date? _____
☐ Yes Years smoking? _____
How many packs? _____
Do you drink alcohol beverages routinely at night? ☐ Yes ☐ No
If yes, how many? _____
Do you drink caffeinated beverages (coffee, tea, soda)? ☐ Yes ☐ No
How many before 6pm?_____How many after 6pm? _____
Do you drink any type of energy drinks? ☐ Yes ☐ No
If yes, how many and what times? _____
If you use any recreational drugs, please list: _____

Have you ever felt the sudden loss of strength (arms/legs) in response to emotional experiences? ☐ Yes ☐ No
Have you ever felt paralyzed when you first wake up or when falling asleep? ☐ Yes ☐ No
Do you ever have vivid or menacing visions while you are falling asleep? ☐ Yes ☐ No
Do you walk in your sleep? ☐ Yes ☐ No
Talk in your sleep? ☐ Yes ☐ No
Do you have nightmares? ☐ Yes ☐ No
Do you ever accidentally urinate in bed? ☐ Yes ☐ No

Are you sleepy or tired during the day? ☐ Yes ☐ No
How many days of the week? _____
When did it start_____weeks_____months_____years
Have you had close calls or accidents when driving due to sleepiness?
☐ Yes ☐ No
Have you had any issues with concentration or memory loss?
☐ Yes ☐ No

PATIENT CLINICIAN

*Please rate your chances of **falling asleep during the DAYTIME** in the following situations using the scale below:*

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

_____ Sitting and reading
_____ Watching television
_____ Sitting inactive in a public place
_____ While a passenger in a car without a break
_____ Laying 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 in traffic for a few minutes

*Rate the severity of your daytime **fatigue (energy level)**:*

0---1-----2----3- - 4- - 5---6- - 7- - 8---9- - 10

None Moderate Severe

Have you been diagnosed with sleep apnea? ☐ Yes ☐ No
If yes, are you on CPAP therapy? ☐ Yes ☐ No
If no, please answer the following:

Do you snore? ☐ Yes ☐ No
If yes, is it loud? ☐ Yes ☐ No
Is it getting worse? ☐ Yes ☐ No
Do you snore on your back? ☐ Yes ☐ No In a chair? ☐ Yes ☐No
Do you gasp or choke during sleep? ☐ Yes ☐ No
Has anyone ever noticed you stop breathing during sleep? ☐ Yes ☐ No
Do you wake with a dry mouth? ☐ Yes ☐ No ☐ Sometimes
headache? ☐ Yes ☐ No ☐ Sometimes

If you have had a sleep study in the past, please bring a copy of the report.

If you are on a CPAP, please bring machine to appointment.

Health Questionnaire:

Allergies:_____ ☐ None

Please list any current or past illnesses/medical conditions you have been treated for:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list all current medications: ***If PMC patient, this is not needed.***

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____