Pinehurst Medical Clinic

Sleep Medicine Questionnaire

Name: ______________________________________ Date: ______________
Referring Doctor: ____

Why are you seeing 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 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? ________________

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Do you work outside the home? ☐ 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:

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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

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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 you legs while sleeping? *(Bed partner complains)*
☐ Yes ☐ No ☐ Don't know

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Currently smoking? ☐ Yes ☐ No
Years smoking? _____ How many packs? ______ Quit date ___________
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: ___________________________

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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

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Are you sleepy or tired during the day? ☐ Yes ☐ No
How many days of the week? _______
When did it start _____weeks ______months _____years
Is it worsening? ☐ Yes ☐ No
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

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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 the machine to your appointment.

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Health Questionnaire:
Allergies: ______________________________________ ☐ None

Please list any current or past illnesses/medical conditions you have been treated for:
1. ______________________ 3. ________________________
2. ______________________ 4, ________________________

Please list all current medications**:** ***If PMC patient, this is not needed.***
1. ______________________ 5. ________________________
2. ______________________ 6. ________________________
3. ______________________ 7. ________________________
4. ______________________ 8. ________________________