

SLEEP CENTER PATIENT HEALTH QUESTIONNAIRE **today's date:** _____

NAME: _____

Date of birth: _____

Emergency Contact: _____ Emergency Number: _____

Check all that apply: (Detailed information is necessary for an accurate sleep study interpretation)

CIRCLE THE SPECIFIC ANSWERS THAT APPLY

MEDICAL PROBLEMS:

Cardiovascular disease (please specify)

coronary artery disease

congestive heart failure

irregular heart rhythm

history of heart surgery

pacemaker/defibrillator

heart valve problems (except mitral prolapse))

High blood pressure (even if effectively treated with medications)

Neurological problem (please specify)

including stroke parkinson's disease

multiple sclerosis

chronic headaches

neuromuscular disease

Chronic lung disease or **active smoking** (please specify)

Attention deficit disorder

Chronic fatigue syndrome

Fibromyalgia

Depression

Chronic use of sleeping pills or **narcotic pain medications**

Physical findings:

Obesity (> 10% above ideal body weight) **enlarged neck** (> 17 in (men), >16 in (women))

Small mouth/throat

enlarged tonsils

significant overbite

small and 'set-back' lower jaw

enlarged tongue

Chronic leg swelling (both legs)

Signs or symptoms:

Motor vehicle accident or "near miss" attributable to falling asleep while driving or frequent **sleepiness while driving**

Witnessed pauses in breathing during sleep

choking episodes during sleep

Loud snoring

Heartburn/acid reflux awakening from sleep

awakening with a **dry mouth or throat**

Frequently awakening tired or unrefreshed

requiring a nap > 2 days per week

Awakening more than 2 times per night (even to use bathroom)

Insomnia

Prefer to avoid sleeping on your back

Sleepwalking as an adult

prominent dreaming > 2 days per week

HEIGHT:

WEIGHT:

NECK SIZE:

BP before study:

BP after study:

(PLEASE TURN OVER)

PLEASE LIST ALL OF YOUR MEDICATIONS (including sleeping pills, vitamins and over-the-counter meds)

PLEASE LIST OTHER RELEVANT MEDICAL HISTORY, SURGERIES ALLERGIES or other information:

WHAT IS YOUR USUAL SLEEPING AND WAKING TIME and how many times do you awaken in between: Any changes on weekends?

HOW MUCH CAFFEINE DO YOU DRINK? _____

HOW MUCH DO YOU SMOKE? _____ (and for how many years)

WHAT IS YOUR OCCUPATION? (and include if you are a pilot as a hobby)

PLEASE DESCRIBE YOUR SPECIFIC SLEEPING PROBLEM:

(including abnormal leg movements, bizarre dreaming, history of seizures, sleep paralysis, hallucinations, feelings of weakness or heaviness that occur after laughter or surprise etc)

EPWORTH SLEEPINESS SCALE:

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

- | | |
|--|-------|
| 1. Sitting and reading | _____ |
| 2. Watching TV | _____ |
| 3. Sitting in a public place (theater, meeting, etc.) | _____ |
| 4. Sitting in a car for 1 hour as passenger | _____ |
| 5. Lying down to rest in afternoon | _____ |
| 6. Sitting and talking to someone | _____ |
| 7. Sitting quietly after lunch without alcohol | _____ |
| 8. In a car, while stopped for a few minutes in traffic | _____ |

TOTAL _____
