

INITIAL CLINIC QUESTIONNAIRE

Comprehensive Sleep Medicine, Inc., P.S.

www.compsleep.com

It is crucial that you bring your fully completed questionnaire with you to your first sleep clinic appointment. Some questions may be challenging to answer; do your best. Feel free to ask your bed partner to help you. Completing this form will make your visit with your doctor much more efficient. Thank you for taking the time to complete this important documentation.

Your full name _____ Date of your clinic visit _____
Date of birth _____ Current age _____ Gender: M / F Are you *right-* or *left-* handed?
First/last name of physician who **referred** you to us: _____
First/last name of primary care physician (if different from above): _____
First/last name of your cardiologist, if you have one: _____
First/last name of your ear/nose/throat doctor, if you have one: _____
First/last name of other pertinent doctors: _____

Please **circle** the main symptom(s) for which you seek help from our sleep clinic:
Snoring Sleepiness Breathing pauses Restless legs Insomnia
Other _____

How did you hear about us? _____

Have you been evaluated in **any** sleep clinic in the past? YES NO

If "yes," it is very important that you complete the enclosed additional 1-page supplemental questionnaire regarding your previous sleep center experiences.

YOUR BREATHING PATTERNS DURING SLEEP

(If already using CPAP, please answer the questions in this section in the context of your CPAP use)

How loud is your snoring?

NO SNORING MILD MODERATE LOUD VERY LOUD

How would you rank the **intensity** of your snoring on a scale of 0 to 5, (0 = no snoring and 5 = "earth-shattering")? 0 1 2 3 4 5

Can the snoring be heard in rooms **outside** your bedroom? YES NO

Does the snoring **disturb** the sleep of those around you? YES NO

Does the snoring force your bed partner to sleep **elsewhere**? YES NO

Has anyone told you that you make **choking** or **gasp**ing sounds during sleep? YES NO

Has anyone ever told you that your breathing **pauses** during sleep YES NO

When were you first told you having breathing pauses during sleep? _____

YOUR SLEEP ENVIRONMENT AND SCHEDULE (please be as **specific** as you can)

Is your sleep environment **dark**? YES NO

Is your sleep environment **quiet**? YES NO

Are your sleep environment and bed **comfortable**? YES NO

If you answered NO to any of these, please explain: _____

Do you sleep with a **child** or **pet**? YES NO Which? _____

Do you **work** at **night**? YES NO If so, work times and days of week: _____

Intentional naps: Days/week _____ Times of day _____ Length of naps _____

Time you typically go to bed on weekdays/workdays:		____:____ a.m./p.m.
What is the earliest you go to bed on weekdays/workdays ?		____:____ a.m./p.m.
What is the latest you go to bed on weekdays/workdays ?		____:____ a.m./p.m.
How long does it take you to fall asleep? (give a range) _____		
Time you typically awaken and arise on weekdays/workdays:		____:____ a.m./p.m.
What is the earliest you arise from bed on weekdays/workdays ?		____:____ a.m./p.m.
What is the latest you arise from bed on weekdays/workdays ?		____:____ a.m./p.m.
Do you use an alarm clock or wake up call?	YES	NO
Time you typically go to bed on days off/weekends:		____:____ a.m./p.m.
What is the earliest you go to bed on days off/weekends ?		____:____ a.m./p.m.
What is the latest you go to bed on days off/weekends ?		____:____ a.m./p.m.
How long does it take you to fall asleep? (give a range) _____		
Time you typically awaken and arise on days off/weekends:		____:____ a.m./p.m.
What is the earliest you arise from bed on days off/weekends ?		____:____ a.m./p.m.
What is the latest you arise from bed on days off/weekends ?		____:____ a.m./p.m.
Do you use an alarm clock or wake up call?	YES	NO

How many hours do you spend **awake** in bed each day? _____

How many hours do you spend **asleep** in bed per day? _____

How many times do you remember **waking up** on average at night? _____

What typically **causes** your awakenings? (circle all that apply)

Snoring/snorting	Leg movements	Joint pain	Choking/gasping	Leg discomfort
Worry	Bad dreams	Thirst	Heartburn	Headaches
Hunger	Noises	Bed partner	Pets	Other _____

How many times do you get up to urinate per night? _____

SLEEP SYMPTOMS (How often do these apply to you? Please circle appropriate number)

	Never	Very rare (once per month or less)	Occasional (once per week)	Often (2 to 4 times per week)	All the time
Snoring or snorting sounds	0	1	2	3	4
Breathing pauses during sleep	0	1	2	3	4
Wake up choking or gasping	0	1	2	3	4
Wake up with sensation of shortness of breath	0	1	2	3	4
Wake up with a dry mouth	0	1	2	3	4
Wake up with a sore throat	0	1	2	3	4
Wake with a morning headache	0	1	2	3	4
Wake up feeling that your heart is beating rapidly or irregularly	0	1	2	3	4
Nasal or sinus congestion	0	1	2	3	4
Heartburn interfering with sleep	0	1	2	3	4
Grind teeth when sleeping	0	1	2	3	4
Nightmares	0	1	2	3	4
Wake up feeling tired	0	1	2	3	4
Have difficulty waking up	0	1	2	3	4

Feel tired or sleepy during waking hours	0	1	2	3	4
Daytime fatigue is a problem for me	0	1	2	3	4
Feel that you are not getting enough sleep	0	1	2	3	4
Sleep walking	0	1	2	3	4
Sleep talking	0	1	2	3	4
Physically acting out dreams while sleeping	0	1	2	3	4
Sudden jerking of the legs	0	1	2	3	4
Rhythmic movement of the legs while sleeping	0	1	2	3	4
Restlessness or discomfort of the legs	0	1	2	3	4
Hallucinations when falling asleep or upon awakening	0	1	2	3	4
Momentary but complete paralysis when falling asleep or upon awakening	0	1	2	3	4
Brief episodes of muscle weakness brought on by strong emotion when you are awake	0	1	2	3	4
I have trouble falling asleep	0	1	2	3	4
I wake up too early in the morning and have trouble getting back to sleep	0	1	2	3	4
I wake up frequently and have trouble getting back to sleep	0	1	2	3	4
I wake up frequently and have NO problem getting back to sleep	0	1	2	3	4

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP (NOT JUST FEEL TIRED) IN THE FOLLOWING SITUATIONS? *Note: this refers to your usual way of life in recent times. If you have not done some of these things recently, try to determine the ways in which you might be in these situations.*

<u>EPWORTH SLEEPINESS SCALE</u>	No chance	Slight chance	Moderate chance	High chance
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (like a theater or a meeting)	0	1	2	3
Riding 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 to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

_____/24

DO YOU EVER BECOME DROWSY WHILE DRIVING ?	YES	NO
HAVE YOU EVER FALLEN ASLEEP BEHIND THE WHEEL ?	YES	NO

Fatigue Severity Scale
 During the past week I have found that :

	Disagree	1	2	3	4	5	6	7	Agree
1. My motivation is lower when I am fatigued	1	2	3	4	5	6	7		
2. Exercise brings on my fatigue	1	2	3	4	5	6	7		
3. I am easily fatigued	1	2	3	4	5	6	7		
4. Fatigue interferes with my physical functioning	1	2	3	4	5	6	7		
5. Fatigue causes frequent problems for me	1	2	3	4	5	6	7		
6. My fatigue prevents sustained physical functioning	1	2	3	4	5	6	7		
7. Fatigue interferes with carrying out certain duties and responsibilities	1	2	3	4	5	6	7		
8. Fatigue is among my three most disabling symptoms	1	2	3	4	5	6	7		
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7		
	Total Score _____								

YOUR PAST MEDICAL HISTORY

Have you ever been told that you had elevated blood pressures ?	YES	NO
Do you have headaches when you awaken in the morning?	YES	NO
Have you ever been told that you have low iron levels ?	YES	NO
In the morning do your mouth, throat or nose feel DRY SORE CONGESTED		
Do you tend to move/kick your legs at night due to discomfort ?	YES	NO
If so, do the movements make your legs feel better ?	YES	NO
If so, can you stop the leg movements if you tried?	YES	NO

Please check all that apply:

CARDIAC	GASTROINTESTINAL	ENDOCRINE
Heart attack or atherosclerosis	Ulcers	Diabetes
Chest pain or angina	Reflux	Hypothyroidism
Atrial fibrillation	Liver disease	Hyperthyroidism
Palpitations	Colitis	Obesity
High blood pressure	Constipation	PSYCHIATRIC
High cholesterol	Irritable bowel syndrome	Diagnosed depression
Heart failure	EAR/NOSE/THROAT	Anxiety disorder
RESPIRATORY	Recurrent sinus infections	Bipolar disorder
Smoking	Allergies	Schizophrenia
Asthma	Nasal congestion	Alcoholism
Bronchitis	NEUROLOGIC	KIDNEYS AND BLADDER
Emphysema/COPD	Stroke	Urinary incontinence
MUSCULOSKELETAL	Seizure disorder	Prostate enlargement
Arthritis	Parkinson's disease	OTHER
Low back pain	Migraine headaches	Anemia (any history)
Neck pain	Head trauma	Cancer: type?
Knee/hip pain	Spinal cord injury	List all others here:
Shoulder pain	Herniated disc	
Fibromyalgia		

Current **weight** _____ Weight 2 years ago _____ Height _____ Collar size _____

Please list every **surgery** you have had: _____
 Have you ever had any **tonsil, adenoid, throat, or nose surgery**? YES NO
 What surgery and your age at time of surgery? _____

Are you <u>ALLERGIC</u> to any medications ?	YES NO
List all allergies and reactions _____	

CURRENT MEDICATIONS (list all your medications, including over-the-counter medicines)

Medication	Dosage	Times per day	Medication	Dosage	Times per day

Have you ever taken medications to improve your sleep? YES NO
 What medications and were they effective? _____

YOUR FAMILY HISTORY (which family members, such as a parent, have had the following?)

Loud **snoring**: _____ **Sleep apnea**: _____
 Early heart disease, stroke, or death: _____
 Unusual or other pertinent medical problems: _____
 Other sleep disorders like narcolepsy (please specify): _____

YOUR SOCIAL HISTORY

Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Boyfriend/girlfriend	Children: <input type="checkbox"/> None <input type="checkbox"/> Yes but not living with me <input type="checkbox"/> Yes, living with me Ages _____	Work status: <input type="checkbox"/> Employed full-time <input type="checkbox"/> Employed part-time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed/disabled (why? _____) <input type="checkbox"/> Student
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Occupation (brief description) _____

Do you have a **commercial driver's license (CDL)**? YES NO
 Are you a **pilot** of any sort or an **air traffic controller**? YES NO

YOUR HABITS

How many **caffeine**-containing beverages do you consume on a typical day?
 Coffee _____ Tea _____ Caffeinated soft drinks _____
 At what time do you typically consume your **last** caffeinated drink? ___:___ am/pm

Alcohol use: how much and at what time of day? _____

Tobacco use:

Never
 Current smoker: # years of smoking _____ Average # packs/day _____
 Former smoker: Quit date _____ # yrs smoked _____ # packs/day _____

Do you use illicit street **drugs**? YES NO If "yes," please list: _____

YOUR REVIEW OF SYSTEMS (check all boxes that apply)

NEUROLOGIC		GASTROINTESTINAL		EAR/NOSE/THROAT	
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	Hearing loss
<input type="checkbox"/>	Dizzy spells	<input type="checkbox"/>	Nausea or vomiting	<input type="checkbox"/>	Ear aches
<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Sinus pain
<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	TMJ pain or jaw clicking
<input type="checkbox"/>	Memory problems	<input type="checkbox"/>	Bloody or black stools	<input type="checkbox"/>	Nasal congestion
<input type="checkbox"/>	Numbness/tingling	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	Nasal drainage
<input type="checkbox"/>	Weakness	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Nasal polyps
HEART		<input type="checkbox"/>	Vomiting blood	<input type="checkbox"/>	Nose bleeds
<input type="checkbox"/>	Chest pain	MUSCULOSKELETAL/SKIN		<input type="checkbox"/>	Mouth sores
<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Joint pain/swelling	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	Swelling of feet/ankles	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	Allergies (seasonal or chronic)
LUNG		<input type="checkbox"/>	Back pain	ENDOCRINE	
<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	Heat/cold intolerance
<input type="checkbox"/>	Coughing	<input type="checkbox"/>	Rash	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	Coughing up blood	BLOOD		<input type="checkbox"/>	Excessive thirst
<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Anemia	PSYCHIATRIC	
KIDNEY/BLADDER		<input type="checkbox"/>	Easy bruising/bleeding	<input type="checkbox"/>	Anxiety/nervousness
<input type="checkbox"/>	Urinate frequently	GENERAL		<input type="checkbox"/>	Depression/sadness
<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	Fever	<input type="checkbox"/>	Suicidal thoughts
<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	Homicidal thoughts
<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>	Hallucinations
<input type="checkbox"/>	Urinary incontinence	<input type="checkbox"/>	Unexpected weight loss	EYES	
<input type="checkbox"/>	Sexual difficulty	<input type="checkbox"/>	Weight gain	<input type="checkbox"/>	Visual changes
SKIN				<input type="checkbox"/>	Eye pain
<input type="checkbox"/>	Abnormal hair growth	<input type="checkbox"/>	Eczema/rashes/itching	<input type="checkbox"/>	Double vision

If you have noticed any chest pain, chest pressure, and/or palpitations, it is very important that your primary care physician be aware of your symptoms. Please seek medical attention right away in the event of such symptoms.

Feel free to write in any additional pertinent comments here.

I have completed this form truthfully and to the best of my ability. I understand that I am fully responsible for its contents and its omissions.

Patient signature _____ **Date** _____