

COMPREHENSIVE SLEEP MEDICINE CLINIC QUESTIONNAIRE

Please make sure to bring this completed questionnaire with you to your sleep clinic appointment. Our staff strives to understand your sleep symptoms, which may be complex in nature. Thank you for taking the time to complete this documentation.

Your full name _____ Date of your clinic visit _____
Date of birth _____ Current age _____ Gender: **M / F**; Are you *right-* or *left-* handed?
Name of physician who referred you to us: _____
Name of primary care physician (if different from above): _____
Name(s) of other health providers to whom our clinical information should be sent:

Please circle the main symptoms for which you seek help from our sleep clinic.
Snoring Sleepiness Breathing pauses Restless legs Insomnia
Other _____

Have you been evaluated in a sleep clinic in the past? YES NO
If "yes," please complete this section and provide for us copies of any available previous written sleep study reports and evaluations.

If "no," please skip this section and go to "your breathing patterns during sleep."
If so, where and when? _____

Were you diagnosed with obstructive sleep apnea? YES NO

Please list any other diagnoses: _____

Have you been treated with a **CPAP** machine? YES NO

Are you **still** using CPAP? YES NO

If not, **why not?** _____

Pressure setting: _____ Your medical equipment company: _____

Have you had snoring or sleep apnea surgery? YES NO

If yes, list dates/location _____

If still using CPAP, please answer the below questions in the context of your CPAP use.

YOUR BREATHING PATTERNS DURING SLEEP:

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? _____

Physician Signature/Initials _____

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YOUR TYPICAL SLEEP SCHEDULE:

What time do you typically go to bed on weekdays? _____:_____ **a.m./p.m.**

What is the **earliest** you go to bed on **weekdays**? _____:_____ a.m./p.m.

What is the **latest** you go to bed on **weekdays**? _____:_____ a.m./p.m.

How long does it take you to fall asleep? _____

What time do you typically awaken on weekdays? _____:_____ **a.m./p.m.**

What is the **earliest** you arise from bed on **weekdays**? _____:_____ a.m./p.m.

What is the **latest** you arise from bed on **weekdays**? _____:_____ a.m./p.m.

Do you use an alarm clock or wake up call? YES NO

What time do you typically go to bed on days off? _____:_____ **a.m./p.m.**

What is the **earliest** you go to bed on **days off**? _____:_____ a.m./p.m.

What is the **latest** you go to bed on **days off**? _____:_____ a.m./p.m.

How long does it take you to fall asleep? _____

What time do you typically awaken on days off? _____:_____ **a.m./p.m.**

What is the **earliest** you arise from bed on **days off**? _____:_____ a.m./p.m.

What is the **latest** you arise from bed on **days off**? _____:_____ a.m./p.m.

Do you use an alarm clock or wake up call? YES NO

Is your sleep environment dark? YES NO

Is your sleep environment quiet? YES NO

Is your sleep environment comfortable? YES NO

If you answered NO to any of these three questions please explain _____

Do you sleep with a child? YES NO

Do you sleep with a cat or dog? YES NO

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

What typically **causes** your awakenings?

Snoring/snorting _____ Leg movements _____ Joint pain _____

Choking/gasping _____ Leg discomfort _____ Worry _____

Bad dreams _____ Thirst _____ Heartburn _____

Headaches _____ Hunger _____ Noise _____

Bed partner _____ Pets _____ Other _____

Need of urination _____, How many times do you get up to urinate per night? _____

Do you **nap intentionally**? YES NO

How many days per week? _____

What time of day? _____

For how long? _____

Do you **accidentally or intentionally doze** off during the day or evening? YES NO

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

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

Have you ever taken medications to improve your sleep? YES NO

What medications and were they effective? _____

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How often does each item apply to you? (Please circle the appropriate number)

	<u>Never</u>	<u>Very rare</u> (once per month or less)	<u>Occasional</u> (once per week)	<u>Often</u> (2 to 4 times per week)	<u>All the time</u>
Make 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

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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.*

	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
At the dinner table	0	1	2	3
While driving	0	1	2	3

Fatigue Severity Scale

During the past week I have found that :

	Disagree ----- 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
 Have you ever had your **tonsils** removed? YES NO When? _____
 Have you ever been told that you have low **iron levels**? YES NO
 Do your **mouth, throat** or **nose** feel badly when you wake up? YES NO
 If so, do they 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

Past Medical History (please check all that apply)

CARDIAC		GASTROINTESTINAL		ENDOCRINE	
Heart attack/Atherosclerosis		Ulcers		Diabetes	
Chest pain/Angina		Reflux		Hypothyroidism	
Atrial fibrillation		Liver disease		Hyperthyroidism	
Palpitations		Colitis		Obesity	
High blood pressure		Constipation		PSYCHIATRIC	
High cholesterol		Irritable bowel syndrome		Depression	
Heart failure		EAR/NOSE/THROAT		Anxiety disorder	
RESPIRATORY		Recurrent sinus infections		Bipolar	
Smoking		Allergies		Schizophrenia	
Asthma		Nasal congestion		Alcoholism	
Bronchitis		NEUROLOGIC		KINDEYS 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			
Shoulder pain		Herniated disc			
Fibromyalgia					

Do you have any other medical problems not listed? _____

Past Surgical History (please list every surgery you have had)

Have you ever had surgery on your TONSILS...ADENOIDS...or...NOSE?

Medication Allergies (list all and type of reaction) NONE

Medications (list all medications, including over the counter medications)

Medication	Dosage	Times per day	Medication	Dosage	Times per day

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YOUR FAMILY HISTORY:

Does anyone in your immediate family (parents, sibling or children) have the following medical conditions? Please indicate **F** for father, **M** for mother, **S** for sibling and **C** for child.

SLEEP DISORDER		CANCER		PSYCHIATRIC	
<input type="checkbox"/>	Sleep apnea	<input type="checkbox"/>	Breast cancer	<input type="checkbox"/>	Anxiety/depression
<input type="checkbox"/>	Snoring	<input type="checkbox"/>	Colon cancer	<input type="checkbox"/>	Bipolar or schizophrenia
<input type="checkbox"/>	Narcolepsy	<input type="checkbox"/>	Prostate cancer	<input type="checkbox"/>	Alcoholism
<input type="checkbox"/>	Restless legs syndrome	<input type="checkbox"/> Other _____		NEUROLOGY	
<input type="checkbox"/>	Insomnia			<input type="checkbox"/>	Parkinson's disease
ENDOCRINE		HEART DISEASE		<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Arrhythmia	<input type="checkbox"/>	Seizure
<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	Heart attack	OTHER	
LUNG DISEASE		<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	Liver disease
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Kidney failure
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Heart failure	<input type="checkbox"/>	Blood clots

YOUR SOCIAL HISTORY:

Marriage status:

- Single
- Married
- Widowed
- Divorced
- Domestic partner

Children:

- None
- Yes but not living with me
- Yes, living with me

Ages _____

Work status:

- Full time employment
- Part time employment
- Retired
- Unemployed/disabled
- Student

Occupation (brief description) _____

If "**disabled**," due to what? _____

Do you have a **commercial driver's license**? YES NO

Do you have a **pilot's license**? 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

Alcoholic beverages: how often and what time of day? (Please be specific)

Your history of **tobacco** use:

- Never
- Current smoker: # Years of smoking _____ Average # packs/day _____
- Former smoker:

Quit date _____ Approx # of years smoked _____ Average # packs/day _____

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

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YOUR REVIEW OF SYSTEMS: (check boxes that apply)

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

Please complete as **accurately** as possible:

Current **weight** _____ Weight two years ago _____ Weight, age 18 _____
 Height _____ Collar size (men) _____

Thank you again for taking the time to fill out this document. Doing so will make your clinic visit with your doctor more efficient. Feel free to write down other issues you might have regarding your sleep. You may ask your bed partner for additional comments as well.

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