ST. VINCENT SLEEP DISORDERS CENTER

PATIENT QUESTIONNAIRE

Name _____ Today's Date _____ Appt. Date _____
Address _____ City _____
State ____ Zip _____ Male ___ Female ___ Marital Status ___ Home Phone _____
Cell Phone _____ Alternate Number_____ (Relationship to Patient) _____
Date of Birth _____ Age _____ Height _____ Weight _____ Neck Size _____
Employer _____ Occupation _____
Family Physician _____ Phone _____

Briefly describe sleep your sleep problem: _____
_____

Have you now or **ever** in the past experienced any health problems in the following areas? If so, please indicate dates, types of problem and treatment, if any.

AREA	DATE	TYPE OF PROBLEM	TREATMENT
Lungs/Breathing			
Heart/Circulation			
Blood Pressure			
Weight			
Diabetes/Thyroid			
Stomach/Digestion			
Kidney/Bowel			
Eye/Ear/Nose/Throat			
Bone/Joint			
Mental Illness			
Sexual			
Other			

List any known allergies: _____

List **any** hospital admissions, including any surgical or psychiatric admissions.

DATE	REASON	LOCATION

Last physical exam:

DATE	PHYSICIAN	RESULTS

List **any** medications, including prescription or over-the-counter, used regularly or occasionally.

MEDICATION	REASON USED	DOSAGE	HOW OFTEN TAKEN	DATE PRESCRIBED	PRESCRIBING DOCTOR

Have you **ever** taken any medication (prescription/over-the-counter) to help you to sleep or stay awake?

MEDICATION	REASON USED	DOSAGE/HOW OFTEN	HOW LONG TAKEN	LAST DOSE

For each of the beverages listed below, write the average amount you drink daily.

TYPE OF BEVERAGE	# PER DAY	MORNING	AFTERNOON	EVENING
Coffee/Tea (caffeinated)				
Soft Drink (caffeinated)				
Decaf Coffee				
Decaf Soft Drink				
Decaf/Herbal Tea				
Alcoholic Beverages				

For each tobacco product listed below, write the amount used during a 24-hour period.

TYPE OF PRODUCT	# PER DAY	# YEARS
Cigarettes	(Packs)	
Cigars		
Pipe	(Bowls)	

Have you ever used street drugs?

TYPE OF DRUG	YES	NO	HOW MUCH?	HOW OFTEN?	FOR HOW LONG?
Marijuana					
Cocaine					
Hallucinogenic drugs (LSD, mescaline, PCP)					
Stimulants (uppers, diet pills)					
Depressants (downers)					
Narcotics (heroin, morphine, opium)					
Other (glue sniffing, etc.) please list:					

If employed, what are your usual working hours? Start ____ am / pm Stop ____ am / pm
What time on week days do you usually: Go to bed ____ am / pm Get up ____ am / pm
How do you normally awaken? Alarm clock ___ Spontaneously___
Other (explain): _____
On average, how many hours per week do you work? ____ hours

(**PLEASE ANSER TO THE BEST OF YOUR ABILITY)**	**YES**	**NO**
Do you work split shifts (is your work day broken into two or more separate work periods?)		
Does your job involve weekend work?		
At the present time, do you work at more than one job?		
Do you snore?		
Does anyone complain about your snoring?		
Do you have nasal/sinus congestion?		
Does someone (or do any pets) sleep in bed with you?		
Do you hold your breath or stop breathing during sleep?		
Do you ever awaken wheezing or short of breath?		
Do you have restless sleep?		
Do you ever wet the bed?		
Are you ever bothered by sleepiness during the day?		
Have you ever had a car accident because of falling asleep at the wheel?		
Any family history of narcolepsy?		
Do you feel refreshed after a short nap?		
Do you feel you are depressed?		
Are you often awakened by noise or other environmental factors?		
Have you ever performed a complex act, such as driving a car to the wrong destination and not remembered how you did it?		

(PLEASE ANSWER TO THE BEST OF YOUR ABILITY)	**YES**	**NO**	**# TIMES A NIGHT**	**# NIGHTS A WEEK**
Do you awaken with headaches?				
Do your legs twitch or kick during the night while you are asleep?				
Do you have leg cramps/crawling sensations in your legs while trying to fall asleep?				
Do you awaken with leg cramps?				
Is your sleep disturbed by in digestion, gas or heartburn?				
Do you grind your teeth during sleep?				
Do you walk in your sleep?				
Do you awaken from sleep screaming, violent and confused?				
Are you bothered by frequent awakenings during the night?				

Do you have trouble getting to sleep? Yes ___ No ___
How long does it usually take you to go to sleep? _____ minutes
Is it difficult to awaken and get out of bed after sleeping? Yes ___ No ___
How long does it take to feel alert and functioning after sleeping ____ minutes

When falling asleep, do you ever …	**YES**	**NO**
Have thoughts racing through your mind?		
Feel sad or depressed?		
Feel muscle tension?		
Feel afraid that you may not be able to go to sleep?		

Do you ever have periods of sudden muscle weakness (paralysis/inability to move) when …	**YES**	**NO**
Laughing?		
Angry?		
Startled?		
Going to sleep?		
During the night?		
Upon awakening?		
During the day?		

Please rate the following statements using a scale of 0-3. (0 = would ***never*** dose, 1 = ***slight*** chance of dozing, 2 = ***moderate*** chance of dozing, 3 = ***high*** chance of dozing.)

SITUATION	**CHANCE OF DOZING**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped in traffic	

If there are any other aspects of your sleep/wake behavior or problems not covered by this questionnaire, please describe them here and list anything else not yet covered which especially interferes with your sleep or wakefulness that might be helpful to the interpreting physician or the technologist.

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