Carolinas HealthCare System

Mecklenburg Medical Group

New Patient Sleep Questionnaire

Sleep Medicine Division

Ehrlich C. Tan, MD W. Eric Clemons, MD Jacob C. Coleman, MD

Instructions: Please complete the questionnaire as best you can and bring it with you to your appointment. Brief answers are appreciated. Your answers will help us understand your sleep and your health better and will help target our discussion more effectively. If you have any questions we'll help you when you come in.

Name: _____ Occupation: _____ Date: _____

Male/Female Age: ____ Date of Birth: _____ Height: _____ Weight: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Ok to call 7-8 am? (Y/N)

Referred by: ❑ Dr. _____ ❑ Self ❑ Partner ❑ Other _____

How well do you sleep most nights? (Circle one)

Terrible *Poor* *Neutral* *Fair* *Great*

What are your main concerns about your sleep? **How long has this been a problem? _____ Weeks / Months / Years**

_____

Have you had any previous evaluations, sleep studies, or treatment for this sleep problem or any sleeping problem? _____ Yes _____ No

If yes, briefly describe results and list name of program / physician (***if possible, bring previous sleep studies and/or all CPAP equipment to the visit***):

_____

If you are sleeping better, what do you believe has helped you?

_____

Please list your usual daily work hours (i.e. 8a-5p). Draw an arrow through days that are the same as the previous day. Please note if shifts rotate.

Mon._____ Tue_____ W_____ Th_____ Fri_____ Sat._____ Sun_____

How many hours do you typically sleep each night (or day if you work nights)? _____

Please list what times you sleep (i.e. 11p-7a).

Mon._____ Tue_____ W_____ Th_____ Fri_____ Sat._____ Sun_____.

How long does it take to fall asleep? _____ How frequent do you wake up from sleep? _____

List what wakes you up: _____

_____

How well rested do you feel when you wake up? _____

Do you take naps? _____ When? _____ How long? _____

Do you have problems with nasal congestion at night? (Circle one)

Always *Occasional* *Rare* *Never*

List any allergy medications you take including nasal sprays:

_____

List anything you take for sleep or to keep you alert (medication, supplements, caffeine):

_____

M-692 (6/13)

Sleep Medicine Division

Check off any symptoms that you have experienced (or your spouse, family, friends etc. have observed):

- ❑ I have been told that I snore.
- ❑ My snoring can be heard in the next room.
- ❑ I have difficulty breathing at night.
- ❑ I often wake up gasping for breath.
- ❑ I have been told that I stop breathing while I sleep.
- ❑ I wish I had more energy.
- ❑ I get morning headaches.
- ❑ I am claustrophobic.
- ❑ I fall asleep at times I don't mean to.
- ❑ I get sleepy while driving
- ❑ I have fallen asleep while driving
- ❑ I have trouble concentrating at work or school.
- ❑ I frequently wake up with a dry mouth.
- ❑ I get sweaty in my sleep.
- ❑ I often feel sleepy and struggle to remain alert during the day.
- ❑ I use the bathroom frequently at night.

PLEASE BRIEFLY DESCRIBE ANY CHECKED ITEMS:

_____

_____

❑ My legs feel restless at night making it hard to fall asleep (check one). ❑1-2 ❑3-4 ❑5-7 nights per week

- ❑ I have noticed or been told that I kick and jerk during sleep.
- ❑ I experience an aching or crawling sensation in my legs when sitting or at night.
- ❑ I experience leg pain or cramps at night.
- ❑ Sometimes I can't keep my legs still; I just have to move them to feel comfortable.

PLEASE BRIEFLY DESCRIBE ANY CHECKED ITEMS:

_____

_____

❑ ***I have difficulty falling asleep :*** ❑ 1-2 ❑ 3-4 ❑ 5-7 nights per week

- ❑ I lie awake for half an hour or more before I fall asleep.
- ❑ I often wake up and have trouble going back to sleep.
- ❑ I wake up earlier in the morning than I would like.
- ❑ I expect a problem with sleep several times a week.
- ❑ I worry about things and have trouble relaxing.
- ❑ I can't shut off my mind when in bed.
- ❑ I often feel sad or anxious because I can't sleep.
- ❑ I watch the clock while in bed

❑ ***If I can't sleep, I will (check all that apply):*** ❑ stay in bed for hours awake ❑ get up and do chores or work ❑watch TV ❑ get a snack. ❑ work/play on computer ❑meditate, relax, or read until drowsy ❑take sleep medication

❑ ***In my bedroom I:*** ❑Watch TV ❑Read ❑ Eat ❑Do bills, computer work ❑Exercise ❑Other

❑ ***How much spend time is spent in the bedroom before trying to go to sleep?*** ❑30 min or less ❑1-2 hours ❑ 2+ hours

PLEASE BRIEFLY DESCRIBE ANY CHECKED ITEMS:

_____

_____

- ❑ When I laugh or get angry, I feel like my muscles are going limp or I get weak.
- ❑ I have experienced vivid dreams or hallucinations upon falling asleep or awakening.
- ❑ I sometimes feel paralyzed as I am falling asleep or on awakening.

PLEASE BRIEFLY DESCRIBE ANY CHECKED ITEMS:

_____

_____

- ❑ I wake up at night with an acid/sour taste in my mouth.
- ❑ Pain bothers my sleep (back, neck, hips, knees, etc.)
- ❑ I wake up at night coughing, choking or wheezing.
- ❑ I have heartburn at night.

PLEASE BRIEFLY DESCRIBE ANY CHECKED ITEMS:

_____

_____

Please check all that apply to you

- ❑ I sleepwalk.
- ❑ I act out my dreams.
- ❑ I eat during my sleep.
- ❑ I wet the bed during sleep.
- ❑ I have disturbing dreams.
- ❑
- ❑ I talk in my sleep.
- ❑ I have hurt myself or others, when I was asleep.
- ❑ I grit or grind my teeth while asleep.
- ❑ I have problems with sexual functioning.
- ❑ I wake up screaming or afraid.

PLEASE BRIEFLY DESCRIBE ANY CHECKED ITEMS:

_____

_____

_____

_____

In general, how sleepy or awake do you feel in the daytime or when you want to be awake (i.e. at night if you work nights)? *(Circle one)*

Very Sleepy.....Drowsy if inactive.....Neutral.....Rarely Drowsy.....Fully Awake .

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation.

0 = no chance of dozing
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 with someone.....	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

TOTAL _____

Personal Medical History

Please check any conditions that you have had

❑ Allergies (Seasonal)	❑ Heart attack	❑ Seizures	❑ Restless Leg Syndrome
❑ Anemia	❑ Heart disease	❑ Stroke	❑ Other
❑ Headaches	❑ High Blood Pressure	❑ Cancer	❑ Other
❑ Arthritis	❑ High Cholesterol	❑ Parkinson's Disease	
❑ Asthma	❑ Fibromyalgia	❑ Thyroid disease	
❑ COPD	❑ Depression	❑ Chronic Pain	
❑ Emphysema	❑ Anxiety	❑ Sleep apnea	
❑ Diabetes	❑ Reflux	❑ Narcolepsy	

Current Weight_____ 5 years ago _____ 10 years ago _____

List any surgeries, hospitalizations, or serious injuries you have had.

Type ***Year***

_____

_____

_____

_____

_____

Medication History

Please list all medications you are currently taking (or attach list on separate sheet). Include prescription, over the counter, and herbal medications as well as vitamins and nutritional supplements.

Medication ***Strength*** ***How often taken***

_____

_____

_____

_____

_____

_____

_____

_____

Are you allergic to any medications? Please list medications and reactions.

_____

_____

Sleep Medicine Division

Habit History

How much of each of the following do you drink each day?

	Number of Cups/Glasses	Time of Day (AM, lunch, dinner, before bed)
Caffeinated Coffee	_____	_____
Caffeinated Sodas	_____	_____
Caffeinated Tea	_____	_____
Alcoholic Beverages	_____	_____

If you smoke or have smoked, list how many packs per day: _____ How many years have you smoked? _____

When did you quit? _____

What kind of exercise do you do? _____

What time of day? _____ How often? _____

Social History

Are you: ❑Single ❑Married ❑Separated ❑Divorced ❑Widowed ❑Other

Where are you from? _____

Commute Time to work? _____

Who lives in the same home with you? _____

What are your hobbies? _____

Family Medical History

	Living	*Deceased*	*Age*	*Health Problems*
Father	❑	❑	_____	_____
Mother	❑	❑		
Brothers	❑	❑	_____	_____
	❑	❑	_____	_____
Sisters	❑	❑	_____	_____
	❑	❑	_____	_____
Children	❑	❑	M/F _____	_____
	❑	❑	M/F _____	_____
	❑	❑	M/F _____	_____
	❑	❑	M/F _____	_____

Please list any conditions or diseases that commonly run in your family:

_____

_____

Does anyone in your family have a history of any of the following?

Condition	*Who?*	*Condition*	*Who?*
❑ Snoring	_____	❑ Restless Legs Syndrome	_____
❑ Sleep Apnea	_____	❑ Extreme Sleepiness	_____
❑ Narcolepsy	_____	❑ Epilepsy	_____
❑ Insomnia	_____	❑	_____

Sleep Medicine Division

Review of Systems:

Please indicate if you have experienced any of the following symptoms **in the past several weeks?**

	Yes	No
General		
Have you recently experienced fevers, chills, or sweats?	❑	❑
Any recent change in appetite?	❑	❑
Any change in your weight?	❑	❑
Skin		
Have you noticed:		
Any sores on your skin?	❑	❑
Any skin rashes, dryness, or itching?	❑	❑
Eyes		
Have you had:		
Change in vision?	❑	❑
Itchy, watery eyes?	❑	❑
Ear, Nose, and Throat		
Do you have:		
Any trouble hearing?	❑	❑
Frequent or severe nosebleeds?	❑	❑
Respiratory		
Do you have:		
Persistent or bothersome cough?	❑	❑
Sputum or phlegm between colds?	❑	❑
Shortness of breath or difficulty breathing?	❑	❑
Cardiovascular		
Do you have:		
Pain, tightness, or pressure in your chest?	❑	❑
An irregular heartbeat?	❑	❑
Difficulty lying flat when you sleep?	❑	❑
Gastrointestinal		
Do you have a lot of indigestion or heartburn?	❑	❑
Are you persistently bothered with constipation?	❑	❑
Do you have frequent diarrhea?	❑	❑
Genitourinary		
Do you frequently wake up at night to go to the bathroom?	❑	❑
For men, do you have problems with erectile function?	❑	❑
Central Nervous System		
Do you have frequent or severe headaches?	❑	❑
Are you bothered with persistent memory loss?	❑	❑
Have you ever had convulsions or seizures?	❑	❑
Are bothered by feelings of depression or anxiety (circle one or both)?	❑	❑
Do you have a history of head injury?	❑	❑
Musculoskeletal		
Do you have muscle or joint pain? (Circle: knees, hips, shoulders, back)	❑	❑
Do you have low back pain in bed?	❑	❑
Do you have swelling in your legs?	❑	❑