SL-1429-FRM
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CMC Conway Medical Center | Sleep Disorders Center

Patient Assessment/Questionnaire

(Please use your tab key to move to each blank)

Name _____ Age _____ Date _____

Date of Birth _____ Sex _____ Height _____ ft. _____ in. Weight _____ lbs.

Neck size _____ inches (If known) Body Mass Index (BMI) (If known)

Phone(s) _____ (home) _____ (work) _____ (cell)

Referring Doctor _____ Primary Care Doctor _____

Have you had a previous sleep study? ☐ Yes ☐ No

If yes, what sleep center was it done at? _____

WHAT SLEEP PROBLEM(S) ARE BOTHERING YOU. CHECK THE BOXES BELOW.

Check all that apply to you and your sleep. To the right of each problem, list how long this has bothered you?

☐ Loud snoring _____ years	☐ Difficulty falling asleep _____ years
☐ Excessive daytime sleepiness _____ years	☐ Restless legs, usually at night _____ years
☐ Excessive daytime fatigue _____ years	☐ Wake up frequently during the night _____ years
☐ Non-refreshing sleep _____ years	☐ Wake up early in the morning _____ years

PLEASE RATE HOW OFTEN YOU:
CHECK ALL THAT APPLY

	Never	Rarely	Sometimes	Frequently	Constantly
Do you snore	☐	☐	☐	☐	☐
Snore so loudly that others complain	☐	☐	☐	☐	☐
Snore so loudly that spouse sleeps in different room	☐	☐	☐	☐	☐
Suddenly wake up gasping for breath	☐	☐	☐	☐	☐
Others say that you stop breathing during your sleep	☐	☐	☐	☐	☐
Fall asleep watching TV or sitting on the couch	☐	☐	☐	☐	☐
Fall asleep reading a book or magazine	☐	☐	☐	☐	☐
Fall asleep at school or at work (e.g. at computer)	☐	☐	☐	☐	☐
Fall asleep involuntarily	☐	☐	☐	☐	☐
Almost fallen asleep driving and veered off the road	☐	☐	☐	☐	☐
Had a motor vehicle accident due to falling asleep	☐	☐	☐	☐	☐
Feel tired during the day, especially after lunch	☐	☐	☐	☐	☐
Feel refreshed when you wake up	☐	☐	☐	☐	☐
Feel like you get a good night's sleep	☐	☐	☐	☐	☐
Experience sudden attacks of muscle weakness when laughing, crying, or being highly emotional	☐	☐	☐	☐	☐
Feel unable to move when half-awake and laying in bed (paralyzed when falling asleep or waking up)	☐	☐	☐	☐	☐
Have vivid dream-like scenes while falling asleep (hypnagogic hallucinations)	☐	☐	☐	☐	☐
Have vivid dreams within a few minutes of falling asleep (hypnagogic dreaming)	☐	☐	☐	☐	☐
Remember your dreams	☐	☐	☐	☐	☐

	Never	Rarely	Sometimes	Frequently	Constantly
Act out your dreams	☐	☐	☐	☐	☐
Talk in your sleep	☐	☐	☐	☐	☐
Walk in your sleep	☐	☐	☐	☐	☐
Eat in the middle of the night and are unaware of it	☐	☐	☐	☐	☐
Grind your teeth in your sleep	☐	☐	☐	☐	☐
Experience creepy, crawling, aching feelings in both legs or simply have leg pains	☐	☐	☐	☐	☐
Have an urge to move legs associated with leg discomfort or leg pain	☐	☐	☐	☐	☐
This leg discomfort worsens at night	☐	☐	☐	☐	☐
This leg discomfort worsens at rest or when inactive	☐	☐	☐	☐	☐
This leg discomfort is relieved by movement	☐	☐	☐	☐	☐
Experience nocturnal leg jerking	☐	☐	☐	☐	☐
Have indigestion or esophageal reflux at night	☐	☐	☐	☐	☐
Awaken with chest pain	☐	☐	☐	☐	☐
Awaken from sleep short of breath	☐	☐	☐	☐	☐
Sweat excessively during the night	☐	☐	☐	☐	☐
Have trouble sleeping when you have a cold	☐	☐	☐	☐	☐
Have indigestion or esophageal reflux at night	☐	☐	☐	☐	☐

GENERAL SLEEP HABITS

1. On average, how many hours of actual sleep do you get per night? _____

2. What time do you usually go to bed on the WEEKDAYS? _____ WEEKENDS? _____

   What time do you usually wake up on the WEEKDAYS? _____ WEEKENDS? _____

3. On average, how long does it take you to fall sleep without a sleep aid? _____ With a sleep aid? _____

4. When you are asleep or trying to fall asleep, are you often disturbed by:

☐ Racing thoughts	☐ Restless legs	☐ Pain	☐ Bed Partner
☐ Light	☐ Anxiety	☐ Night sweats	☐ Heat
☐ Pets	☐ Noise	☐ Headaches	☐ Cold
☐ Esophageal reflux		☐ Not being in your usual bed	
☐ Other _____			

5. How many times do you typically wake up at night? _____

   How many of these times is it because you needed to urinate? _____

   On average, how long does it take you to fall asleep after each awakening? _____

6. On average, how long do you stay in bed after waking up in the morning? _____

7. Do you work evening shift, night shift, split shifts, or rotating (variable) shifts? _____

   If so, what is your schedule? _____

8. Do you usually: (Check all that apply)

   ☐ Sleep with someone else in your bed

   ☐ Sleep with someone else in your room

   ☐ Provide assistance to someone during the night (child, invalid, bed partner, animal)

9. Do you wear a dental device when sleeping? ☐ Yes ☐ No If Yes, is it for sleep apnea ☐ or teeth grinding ☐

   If so, please provide dentist's name: _____

10. Do you sleep on more than two pillows: ☐ Yes ☐ No Please check if you have an adjustable bed: ☐ Yes

11. How many cups of coffee, tea, or other caffeinated beverages do you drink in 1 day? _____

12. What time do you usually drink your last cup of a caffeinated beverage? _____

13. Do you usually drink coffee or tea within 2 hours before going to bed? ☐ Yes ☐ No

14. Do you do physical exercise before going to bed? ☐ Yes ☐ No

15. Do you read before falling asleep? ☐ Yes ☐ No

16. Do you take naps during the afternoon or evening? ☐ Never ☐ Seldom ☐ Frequently

17. Do you feel refreshed after a short (10-15 minute) nap? ☐ Yes ☐ No

18. How do you feel after an average night of sleep? ☐ Drowsy/Tired ☐ Usually I feel good ☐ Consistently I feel good

19. If you feel drowsy or tired after an average night of sleep, how long do you feel this way? _____

20. Do you feel better during the? ☐ Morning ☐ Afternoon ☐ Night

21. How much weight have you gained in the last year? _____ lbs Since the age of 18? _____ lbs

PAST MEDICAL HISTORY

Check all that apply:

☐ High Blood Pressure	☐ Esophageal Reflux/Hiatal hernia	☐ Seizures/Epilepsy	☐ Osteoarthritis
☐ Diabetes	☐ Sinus Allergies/Hay fever	☐ Parkinson's Disease	☐ Rheumatoid arthritis
☐ Heart Disease/Heart Attack	☐ Asthma	☐ Dizzy/Blackout Spells	☐ SLE (Lupus)
☐ Congestive Heart Failure	☐ COPD (emphysema)	☐ Chronic back pain	☐ Osteoporosis
☐ Heart murmur	☐ Pregnancy	☐ Chronic neck pain	☐ Depression
☐ Atrial fibrillation	☐ HIV/AIDS	☐ Chronic pain syndrome	☐ Bipolar disorder
☐ Stroke	☐ Hypothyroidism	☐ Fibromyalgia	☐ ADD or ADHD
☐ Elevated cholesterol	☐ Strep throat before 21 years old	☐ Mononucleosis (Mono)	☐ Kidney Disease
☐ Cancer _____	☐ Cancer _____	☐ Other _____	☐ Liver Disease
Type of cancer	Type of cancer	☐ Other _____	☐ Other _____

ENT Surgery or Surgery for Sleep Apnea:

☐ Tonsillectomy	☐ Adenoidectomy	☐ UPPP	☐ LAUP
☐ Nasal surgery	☐ Nasal Septoplasty	☐ Turbinate reduction	☐ Sinus surgery

Other _____

Surgery:

☐ Gallbladder	☐ Appendectomy	☐ Hysterectomy	☐ Mastectomy
☐ Heart bypass surgery	☐ Hernia surgery	☐ Ovaries removed	☐ Back surgery
☐ Gastric bypass surgery	☐ **Joint Replacement:**	_____	_____
		Joint Replaced and Year	**Joint Replaced and Year**

Other surgery: _____

Any complications related to anesthesia or surgery? _____

Vaccinations:

Pneumonia Vaccine (Pneumovax) ☐ No ☐ Yes Date last given _____

Flu Vaccine ☐ No ☐ Yes Date last given _____ Ever had swine flu vaccine? ☐ No ☐ Yes

Usual Childhood Vaccines (if applicable) ☐ No ☐ Yes

MEDICATIONS

Drug	**Dose**	**Frequency**	**Purpose**
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______

ALLERGIES

Medication	Reaction	Medication	Reaction
______	______	______	______
______	______	______	______
______	______	______	______

LANGUAGE/LEARNING

Preferred Learning Method: ☐ Auditory ☐ Visual ☐ Written ☐ Documentation

Preferred Language for Learning: ☐ English ☐ Other: _____

SOCIAL HISTORY

1. Have you ever smoked cigarettes? ☐ Yes ☐ No

2. How much did you smoke? _____ How many years? _____

3. If you have quit smoking, how many years ago did you quit? _____ years ago

4. Do you drink alcohol? ☐ Yes ☐ No

5. What do you drink? ☐ Beer ☐ Wine ☐ Liquor

6. How many alcoholic drinks do you have? _____ per day _____ per week _____ per month

7. Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

8. What is your occupation? _____

9. Is your present work situation satisfactory? _____ Is your present social life satisfactory? _____

10. Has your sleep problem required you to cut back on social activity? _____

11. Does your sleep problem disturb your sex life? _____

12. With whom are you living with now? (wife, husband, children, parents, etc. and their ages)

_____ _____
_____ _____
_____ _____

FAMILY HISTORY

1. Father's Medical Problems _____

   Cause of Death _____ Age at death _____ years old

2. Mother's Medical Problems _____

   Cause of Death _____ Age at death _____ years old

3. Does any other member of your family have other medical problems? Please list.

   Relative _____ Problems _____

   Relative _____ Problems _____

   Relative _____ Problems _____

   Relative _____ Problems _____

4. Does any other member of your family have sleep apnea or other sleep problems? Please explain.

   Relative _____ Sleep Problems _____
   Relative _____ Sleep Problems _____

Review of Systems

CONSTITUTIONAL SYMPTOMS

Good general health	☐ No	☐ Yes
Recent weight loss	☐ No	☐ Yes
Recent weight gain	☐ No	☐ Yes
Fevers	☐ No	☐ Yes
Night sweats	☐ No	☐ Yes
Excessive sleepiness	☐ No	☐ Yes
Fatigue/ Tiredness	☐ No	☐ Yes
Snoring during sleep	☐ No	☐ Yes

EYES

Double vision	☐ No	☐ Yes
Blurred vision	☐ No	☐ Yes
Suffer from Glaucoma	☐ No	☐ Yes

EAR, NOSE, THROAT, AND MOUTH

Ringing in the ears	☐ No	☐ Yes
Difficulty hearing	☐ No	☐ Yes
Earaches	☐ No	☐ Yes
Chronic sinus drainage	☐ No	☐ Yes
Chronic sinus congestion	☐ No	☐ Yes
Frequent sneezing	☐ No	☐ Yes
Mouth sores	☐ No	☐ Yes
Bleeding gums	☐ No	☐ Yes
Bad breath	☐ No	☐ Yes
Swollen glands in neck	☐ No	☐ Yes
Change in voice (hoarseness)	☐ No	☐ Yes

PULMONARY

Chronic cough	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Wheezing	☐ No	☐ Yes
Blood in sputum	☐ No	☐ Yes
Pain with breathing	☐ No	☐ Yes

CARDIOVASCULAR

Chest pains	☐ No	☐ Yes
Palpitations (heart racing)	☐ No	☐ Yes
Swelling of the feet	☐ No	☐ Yes
Shortness of breath on exertion	☐ No	☐ Yes

GASTROINTESTINAL

Heartburn	☐ No	☐ Yes
Nausea or vomiting	☐ No	☐ Yes
Poor appetite	☐ No	☐ Yes
Change in bowel movements	☐ No	☐ Yes
Diarrhea	☐ No	☐ Yes
Constipation	☐ No	☐ Yes
Blood in stool	☐ No	☐ Yes
Black, tarry stools	☐ No	☐ Yes

HEMAOLOGICAL/LYMPHATIC

Easy bruising	☐ No	☐ Yes
Excessive bleeding	☐ No	☐ Yes
Enlarged glands/ lymph nodes	☐ No	☐ Yes

NEUROLOGICAL

Morning headaches	☐ No	☐ Yes
Migraine headaches	☐ No	☐ Yes
Dizziness	☐ No	☐ Yes
Seizures	☐ No	☐ Yes
Tremors	☐ No	☐ Yes
Paralysis/ weakness (extremities)	☐ No	☐ Yes
Numbness/ tingling (hands and feet)	☐ No	☐ Yes

MUSCULOSKELETAL

Joint pains	☐ No	☐ Yes
Joint stiffness	☐ No	☐ Yes
Joint swelling	☐ No	☐ Yes
Back pains	☐ No	☐ Yes
Muscle cramps or pains	☐ No	☐ Yes
Difficulty walking	☐ No	☐ Yes

GENITOURINARY

Frequent urination	☐ No	☐ Yes
Burning urination	☐ No	☐ Yes
Urinary Incontinence	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Sexual problems	☐ No	☐ Yes
Testicular pain (Males)	☐ No	☐ Yes
Vaginal discharge (Females)	☐ No	☐ Yes

INTEGUMENTARY (skin/breast)

Itching or Rash	☐ No	☐ Yes
Varicose veins	☐ No	☐ Yes
Change in skin color	☐ No	☐ Yes
Abnormality in nails/ hair	☐ No	☐ Yes
Breast pain	☐ No	☐ Yes
Breast lump	☐ No	☐ Yes
Nipple discharge	☐ No	☐ Yes

PSYCHIATRIC

Depression	☐ No	☐ Yes
Mood swings	☐ No	☐ Yes
Increased irritability	☐ No	☐ Yes
Difficulty concentrating	☐ No	☐ Yes
Memory loss/ confusion	☐ No	☐ Yes
Nervousness/ anxiety	☐ No	☐ Yes
Difficulty sleeping	☐ No	☐ Yes

ENDOCRINE

Excessive thirst	☐ No	☐ Yes
Poor control of blood sugar	☐ No	☐ Yes
Intolerance to heat	☐ No	☐ Yes
Intolerance to cold	☐ No	☐ Yes
Dry skin	☐ No	☐ Yes
Change in hat or glove size	☐ No	☐ Yes

ALLERIC / IMMUNOLOGIC

Nasal allergies/ Hayfever	☐ No	☐ Yes
Recurrent hives	☐ No	☐ Yes
Allergy to foods	☐ No	☐ Yes

Epworth Sleepiness Scale

Name: _____ Today's Date: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usua 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 below:
0 = would *never* doze 1 = *slight* chance of dozing
2 = *moderate* chance of dozing 3 = *high* chance of dozing

Make sure you check a number for each situation.

SITUATION	CHANCE OF DOZING			
	0	1	2	3
1. Sitting and Reading	☐	☐	☐	☐
2. Watching Television	☐	☐	☐	☐
3. Sitting inactive in a public place (e.g., a theater or meeting)	☐	☐	☐	☐
4. As a passenger in a car for an hour without a break	☐	☐	☐	☐
5. Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
6. Sitting and talking to someone	☐	☐	☐	☐
7. Sitting quietly after lunch without alcohol	☐	☐	☐	☐
8. In a car, while stopped in traffic	☐	☐	☐	☐
			TOTAL SCORE: _____	

(Maximum = 24. Normal < 10)

Fatigue Severity Scale

This questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and check a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you. A low number indicates strong disagreement with the statement, whereas a high value indicates a strong agreement with the statement.

Make sure you check a number for every statement.

During the past week, I have found that:	**Disagree**----------						**Agree**
	very much						**very much**
	1	2	3	4	5	6	7
1. My motivation is lower when I am fatigued	☐	☐	☐	☐	☐	☐	☐
2. Exercise brings on my fatigue	☐	☐	☐	☐	☐	☐	☐
3. I am easily fatigued	☐	☐	☐	☐	☐	☐	☐
4. Fatigue interferes with my physical functioning	☐	☐	☐	☐	☐	☐	☐
5. Fatigue causes frequent problems for me	☐	☐	☐	☐	☐	☐	☐
6. My fatigue prevents sustained physical functioning	☐	☐	☐	☐	☐	☐	☐
7. Fatigue interferes with carrying out certain responsibilities	☐	☐	☐	☐	☐	☐	☐
8. Fatigue is among my three most disabling symptoms	☐	☐	☐	☐	☐	☐	☐
9. Fatigue interferes with my work, family, or social life	☐	☐	☐	☐	☐	☐	☐

TOTAL SCORE: _____

(Maximum = 63. Normal < 36)

Reviewed by medical director or designated sleep staff physician:

_____

Signature Date