Please complete this questionnaire in ink and bring it with you to your appointment.

Date	Review date	Review date

Name	Date of birth	Age

Height	Weight now	Weight 1 yr ago	Gender: (circle one) MALE FEMALE

Occupation	Employer

Shift worker? YES NO If yes, please describe:

How did you first hear of CU Sleep? PHYSICIAN TV RADIO SEMINAR NEWSPAPER INTERNET FRIEND OTHER

Referring physician	City
Regular doctor	City

Has your address, telephone number, or insurance changed recently? YES NO
If so, please put latest information here:

Sleep habits

	Work days	"Weekends"
Bedtime		
Arise time		
Hours of sleep (don't count in bed awake)		
How many minutes it takes to fall asleep		
Usually take how many naps?		

What is your main sleep problem?____________________

____

____

When did this problem begin? ______________________

____

Is the problem … INCREASING DECREASING STAYING SAME

How much do you want to fix this problem?
MUST FIX WOULD **LIKE** TO FIX NOT VERY IMPORTANT

Amount of sleep you need to feel well rested: _____ hours

If you take naps, what is the usual length? _______ minutes

How long it takes you to fully wake up: ________ minutes

Do you find naps refreshing? YES NO

Does your sleep problem affect (circle all that apply):
WORK HOME LIFE RELATIONSHIPS SAFETY

Epworth Sleepiness Scale

How likely are you to actually doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale to choose the most appropriate number for each situation:

0 = would **never** doze
1 = **slight** chance of dozing
2 = **moderate** chance of dozing
3 = **high** chance of dozing

Situation

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 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 ___________

Do any of your sleep problems seem to go in cycles? YES NO If yes, describe:

Usual **medications** *(include over-the-counter & herbals)*

Name of medication	What for?

Are you allergic to any medications? YES NO

If yes, which? ______________________________

How many times per week do you take sleeping pills? _____

Below, list other medicines you have taken in the past month *(don't count "usual medications" you already listed at left.)*

Name of medication	What for?

If you do not have room to write your current medications above, please attach a list. Thank you!

Medical history

Have you had a sleep study before? YES NO

If yes, where and when? ______________________________

Do you currently use… **Oxygen?** YES NO **CPAP?** YES NO

If yes, what medical supply company do you use? Flow setting: ______________

______________________________ City: ______________

Any family members diagnosed with sleep disorders or died in their sleep? YES NO

Describe: ______________________________

____

Surgeries & Hospitalizations (MOST RECENT FIRST)

When	Where	What/why

Check off present or past medical conditions ↓

Condition	✓
Diabetes	
High blood pressure	
Heart problems	
Stroke	
Thyroid problems	
Depression	
Seizures / epilepsy	
Kidney trouble	
Heartburn	
Muscle cramps	
Lung disease (COPD)	
Arthritis	
Bladder trouble	
Fainting/dizziness/balance problems	
Sinus problems or nasal allergies	
Deviated septum	
Headaches	
Other: ______________	

Symptoms Check off how frequently you have experienced the items below (in the past 3 - 6 months):	Always	Frequently	Occasionally	Never
Snoring				
Gasping, choking, or short of breath during sleep				
Coughing disrupting sleep				
Awaken with dry mouth				
Wake up with a headache				
Sinus trouble/congestion disrupting sleep				
Difficulty breathing in a flat position				
Others see pauses in my breathing during sleep				
Fall asleep unintentionally				
Feel sleepy during the daytime				
Feeling paralyzed in bed				
Muscle weakness when emotional				
See dreamlike images when not fully asleep				
Wake up and can't get back to sleep				
Unable to fall asleep quickly enough				
Mind races when I try to sleep				
Anxiety or depression				
Tossing and turning				
Urge to walk / move legs when at rest				
Uncomfortable sensations in limbs at rest				
Leg or body jerks				
Sleep walking				
Bed-wetting				
Head-banging or body rocking				
Frightening dreams				
Acting out dreams/nightmares				
Waking up screaming, violent, or confused				
Night sweats				
Teeth-grinding during sleep				
Sleep with another person in the bed				
Sleep with a pet in the bed				
Get up to attend to others at night				
Sleep disturbed by light, noise, or temperature				
Sleep disrupted by urgent need to urinate				
Sleep disrupted by hunger or thirst				
Wake up gagging OR with a sour taste in mouth OR burning throat				
Sleep disrupted by pain or physical discomfort (please describe): ____				

Your current habits	About how many ounces of the following foods/beverages do you consume daily?				
Coffee (with caffeine)		Soft drinks (with caffeine)		Tea (with caffeine)	
Alcoholic drinks		Chocolate		Decaf. Coffee	

Do you smoke, dip, or chew tobacco?	YES NO	Amount/frequency:
Do you exercise regularly?	YES NO	Amount/frequency:

The section below only needs to be filled out when applicable. If no bed partner, leave blank.

BED PARTNER QUESTIONNAIRE

Patient's name: ____________________ Your name: ____________________

I have observed this person's sleep (circle one):
NEVER ONCE OR TWICE OFTEN EVERY NIGHT

Please check off every behavior that applies.

Sleepwalking		Kicking / jerking in sleep	
Sleeptalking		Head banging in sleep	
Light snoring		Body rocking in sleep	
Loud snoring		Sudden snorts in sleep	
Gasping in sleep		Stops breathing in sleep	
Daytime confusion		Grinding teeth in sleep	
Crying out in sleep		Waving arms in sleep	
Shaking fits in sleep		Getting up while asleep	
Bed-wetting		Acts out dreams in sleep	

Please describe in detail the behaviors listed above (or others that you have observed.) Include how frequently it occurs and approximate time of night.

Epworth Sleepiness Scale

How likely is this person to actually doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale to choose the most appropriate number for each situation:

0 = would **never** doze
1 = **slight** chance of dozing
2 = **moderate** chance of dozing
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Situation

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Lying down 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 __________

Has this person ever fallen asleep during normal daytime activities or in dangerous situations? YES NO If yes, explain: