Intake Questionnaire

Patient Information

Physician use only)

Name:_____

Date of Birth:

Month	Day	Year	Age in Years

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Education Level: ☐ High School ☐ College ☐ Other

Occupation:_____

Referring Physician:_____

Your Main Complaints (Reason for Referral)

☐ Daytime Sleepiness (Fill-in all that apply)
☐ Insomnia
☐ Snoring
☐ Interruptions in breathing
☐ Leg jerks
☐ Other, please explain: _____

_____

Your Bedpartner's Main Complaints (About Your Sleep)

☐ Daytime Sleepiness (Fill-in all that apply)
☐ Insomnia
☐ Snoring
☐ Interruptions in breathing
☐ Leg jerks
☐ Other, please explain: _____

_____

Sleep History

How long has your main complaint(s) bothered you! (Fill-in one only)

☐ Within the last 3 months Please estimate how long
☐ Several months (6-12)you have had a sleep
☐ About 1 to 2 years problem _____
☐ Longer than 2 years

On the scale below, how would you rate the severity of your complaint(s)? (Fill in one only)

Mildly Upsetting	Moderately Severe	Very Severe
☐	☐	☐

How strongly do you want help with this problem? (Fill in one only)

Mildly	Moderately	Very
☐	☐	☐

Intake Questionnaire
Previous Evaluations/Treatment

Have you sought medical advice from any other physician regarding your sleep complaint(s)? ☐ Yes ☐ No

Have you had a previous sleep study? ☐ Yes ☐ No If so, when?_____, where_____, physician_____.

What was recommended or tried? (check all that apply)

Medications?

☐ Adderall
☐ Ambien
☐ Ativan
☐ Chloral Hydrate
☐ Celexa
☐ CPAP
☐ Cylert
☐ Dalmane
☐ Desyrel
☐ Dexedrine
☐ Doral
☐ Effexor
☐ Halcion
☐ Klonopin
☐ Paxil
☐ Phenobarbital
☐ Provigil
☐ Prozac
☐ Quinine
☐ Restoril
☐ Ritalin
☐ Sinemet
☐ Sonata
☐ Wellbutrin
☐ Xanax
☐ Other Medications_____

Surgeries?

☐ Nasal Septal Repair
☐ Uvulopalatopharyngoplasty
☐ Somnoplasty
☐ Other Surgeries_____

Suggested Behavioral Changes?

☐ Strict bed schedule
☐ Warm bath
☐ Other Restrictions:_____

Sleep Symptoms

Please rate how often you:	Never	Rarely	Sometimes	Frequently	Constantly
(1) Do you awaken feeling rested and refreshed	☐	☐	☐	☐	☐
(2) Fall asleep before noon if not active	☐	☐	☐	☐	☐
(3) Fall asleep during active tasks before noon	☐	☐	☐	☐	☐
(4) Experience sleepiness before lunch	☐	☐	☐	☐	☐
(5) Fall asleep in the afternoon if not active	☐	☐	☐	☐	☐
(6) Fall asleep during active tasks in the afternoon	☐	☐	☐	☐	☐
(7) Take naps on arrival home from work	☐	☐	☐	☐	☐
(8) Are short naps refreshing (10-15 min)	☐	☐	☐	☐	☐
(9) Fall asleep while driving	☐	☐	☐	☐	☐
(10) Have trouble at school or work due to sleepiness	☐	☐	☐	☐	☐
(11) Have been told you snore	☐	☐	☐	☐	☐
(12) Snore loud enough others complain	☐	☐	☐	☐	☐
(13) Are told you have stopped breathing during sleep	☐	☐	☐	☐	☐
(14) Have awakened from snorting in your sleep	☐	☐	☐	☐	☐
(15) Awaken from sleep short of breath or feeling choked	☐	☐	☐	☐	☐
(16) Awaken at night with heartburn, belching, or coughing	☐	☐	☐	☐	☐
(17) Sweat excessively at night	☐	☐	☐	☐	☐
(18) Awaken at night with chest pain or heaviness	☐	☐	☐	☐	☐
(19) Awaken at night with heart racing or pounding	☐	☐	☐	☐	☐
(20) Have difficulty lying flat in bed because of fullness in the throat	☐	☐	☐	☐	☐
(21) Dry mouth in the morning	☐	☐	☐	☐	☐
(22) Morning headache	☐	☐	☐	☐	☐

Intake Questionnaire

Sleep Symptoms (continued)

Please rate how often you:	Never	Rarely	Sometimes	Frequently	Constantly
(23) Feel the uncontrollable urge to sleep during the day especially when very mad, happy, or sad	☐	☐	☐	☐	☐
(24) Feel knees buckle, arms weak, or jaw droop when mad, happy, or sad	☐	☐	☐	☐	☐
(25) Experience vivid dream-like scenes upon awakening or falling asleep	☐	☐	☐	☐	☐
(26) Feel unable to move (paralyzed) when waking from or falling asleep	☐	☐	☐	☐	☐
(27) Have leg cramps at bedtime	☐	☐	☐	☐	☐
(28) Experience crawling and aching feelings in your arms or legs, which makes you want to move them or walk.	☐	☐	☐	☐	☐
(29) Have been told that your legs move every 20 seconds or so throughout the night	☐	☐	☐	☐	☐
(30) Awakened suddenly with a jerk soon after having fallen asleep	☐	☐	☐	☐	☐
(31) Remember your dreams	☐	☐	☐	☐	☐
(32) Have nightmares	☐	☐	☐	☐	☐
(33) Have been told you act out your dreams or nightmares by swinging your arms or legs or yelling	☐	☐	☐	☐	☐
(34) Have been told you sleepwalk	☐	☐	☐	☐	☐
(35) Have you noticed you get up and eat during the night in your sleep	☐	☐	☐	☐	☐
(36) Have been told that you arouse from sleep totally confused/unconsolable (either as a child or an adult)	☐	☐	☐	☐	☐
(37) Have awakened panicked or anxious	☐	☐	☐	☐	☐
(38) Have experienced uncontrolled urination in your sleep (either as a child or an adult)	☐	☐	☐	☐	☐
(39) Are unable to fall asleep in 15 minutes or less	☐	☐	☐	☐	☐
(40) Wake up several times during the night and cannot get back to sleep	☐	☐	☐	☐	☐
(41) Wake up one to two hours early in the morning	☐	☐	☐	☐	☐
(42) Have thoughts racing through your mind while you are trying to fall asleep	☐	☐	☐	☐	☐
(43) Watch the clock while trying to fall asleep	☐	☐	☐	☐	☐
(44) Feel sad and depressed	☐	☐	☐	☐	☐
(45) Have anxiety (worries about family or financial problems)	☐	☐	☐	☐	☐
(46) Have experienced claustrophobia or get "panicky" in crowded places	☐	☐	☐	☐	☐
(47) Have muscular tension	☐	☐	☐	☐	☐
(48) Are bothered by pain during the day	☐	☐	☐	☐	☐
(49) Experience any type of pain during the night	☐	☐	☐	☐	☐
(50) Wake up feeling stiff in the mornings	☐	☐	☐	☐	☐
(51) Wake up with sore or achy muscles	☐	☐	☐	☐	☐
(52) Wake up with pain in neck, spine, or joints	☐	☐	☐	☐	☐
(53) Have morning jaw pain	☐	☐	☐	☐	☐
(54) Grind teeth during sleep	☐	☐	☐	☐	☐
(55) Clench teeth during the day	☐	☐	☐	☐	☐
(56) Have trouble concentrating	☐	☐	☐	☐	☐
(57) Have poor memory	☐	☐	☐	☐	☐
(58) Has your sexual relationship been affected because you are tired or sleepy	☐	☐	☐	☐	☐

Intake Questionnaire

Epworth Sleepiness scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?
(Check the one selection that best describes your chance of dozing for each situation)

Situation	(0) would *never* doze	(1) *slight* chance of dozing	(2) *moderate* chance of dozing	(3) *high* chance of dozing
(1) Sitting and reading	☐	☐	☐	☐
(2) Watching TV	☐	☐	☐	☐
(3) Sitting, inactive in a public place (ex. theater or a 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 down and talking with someone	☐	☐	☐	☐
(7) Sitting quietly after lunch without alcohol	☐	☐	☐	☐
(8) In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

Epworth Total ____/ 24

Sleep Schedule **for example:**

(1) During the week . . . What time do you normally go to bed? _____ a.m./p.m.
What time do you normally awaken? _____ a.m./p.m.

(2) Over the weekend . . . What time do you normally go to bed? _____ a.m./p.m.
What time do you normally awaken? _____ a.m./p.m.

(3) How long does it take you to get to sleep? _____ min / hours (circle one)

(4) Approximately how many times do you waken during your sleep cycle? _____

(5) How long to get back to sleep? _____ min / hours (circle one)

(6) What are the usual causes that awaken you? (Check all that apply)

☐ Urination
☐ Shortness of breath
☐ Heartburn, or regurgitation of acid
☐ Body jerking
☐ Animal
☐ Unknown / not sure
☐ Heat
☐ Noise
☐ Cold
☐ Light
☐ Child
☐ Other reasons: _____

(7) Do you change or swing shifts at work?
☐ Yes ☐ No If Yes, what hours: _____

(8) Do you work the night shift?
☐ Yes ☐ No If Yes, what hours: _____

(9) Do you experience problems with your sleep when you travel, especially in the eastward direction, i.e. jet lag?
☐ Yes ☐ No

(10) Do you sleep separately from your bed partner?
☐ Yes ☐ No If Yes, how long: _____

(11) Does your bed partner, or you, leave the bedroom because of your sleep problem?
☐ Yes ☐ No

Intake Questionnaire

Past Surgical History

Have you had any operations? (If yes, please list below with year)

Past Medical History

In the box below, please list any major illnesses or hospitalizations you have had (if known & year)

Family History

If no, what was their age and cause of death (if known)?

(1) Is your biological mother still living?
☐ Yes ☐ No _____ Age: ☐☐ Age: ☐☐ Cause: _____ **Mom**

(2) Is your biological father still living?
☐ Yes ☐ No _____ Age: ☐☐ Age: ☐☐ Cause: _____ **Dad**

(3) How many siblings and children do you have? How many are still living?
If any are deceased, what was the cause of death (if known)?

☐ brothers ☐ # living _____ **Bro**

☐ sisters ☐ # living _____ **Sis**

☐ children ☐ # living _____ **Ch**

(4) Does your family have a history of sleep disorders?
☐ Yes ☐ No Describe _____

Physician use only

Social History

(1) Do you presently live alone?
☐ Yes ☐ No

(2) What is your education level?
(Check the one that best represents the highest degree or education obtained)

☐ Did not finish high school
☐ High school graduate
☐ 2 year college/technical school graduate
☐ 4 year college/university degree
☐ Advanced degree (M.S., M.B.A., Ph.D., M.D., etc.)

Physician use only)

Intake Questionnaire

Tobacco Use History

(1) Were you *ever* a regular tobacco user (cigarettes, cigars, chewing tobacco, or pipe?) ☐ Yes ☐ No

If **"NO"**, please skip to **"Drinking History"** on the next page.

(2) Approximately how many total years were you a tobacco user ☐☐ years

(3) When you regularly used tobacco, which one selection most accurately represents your daily level of use? (Fill in one only)

- ☐ Mild (3 or less cigarettes, 1 can/pouch, under 1 pipe bag per week, etc.)
- ☐ Semi-Moderate (about a half-pack of cigarettes per day, etc.)
- ☐ Moderate (A pack a day, 1 can/pouch, a pipe bag a day, etc.)
- ☐ Heavy (Two packs a day, 2 cans/pouches, 2 pipe bags per day)
- ☐ Very Heavy (Three or more packs, etc. a day)

(4) Are you currently a regular tobacco user (cigarettes, cigars, chewing tobacco, or pipe)?

☐ Yes ☐ No

(5) If **"No"**, how long ago did you quit? ☐☐ years

Physician use only)

Drinking History

(1) Do you drink coffee?

☐ Yes ☐ No

(2) If yes, approximately how much? ☐☐ cups per day

(3) Do you drink Tea?

☐ Yes ☐ No

(4) If yes, approximately how much? ☐☐ cups per day

(5) Do you drink soft drinks (Coke, Pepsi, etc.)?

☐ Yes ☐ No

(6) If yes, approximately how much? ☐☐ cans/bottles per day

(7) How close to your bedtime do you drink coffee, tea, or soft drinks?

(Check one only)

- ☐ At bedtime
- ☐ Less than 1 hour
- ☐ 1-2 hours
- ☐ more than 2 hours

(8) Do you drink alcohol?

☐ Yes ☐ No

(9) If yes, approximately how many servings per day?

Note: one serving = can of beer, glass of wine, or shot of hard liquor

(Check one only)

- ☐ 1 or less per day
- ☐ 1 to 3 per day
- ☐ 3 to 6 per day
- ☐ more than 6 per day

(10) Do you currently take any "str. drugs"?

☐ Yes ☐ No

(11) Do you currently use Aspartame (Nutra-Sweet, Equal)? ☐ Yes ☐ No

Medications

Please list any medications you are taking and the dosage (if known), including vitamins and herbs

Review of Systems General

Allergies / Immunologic

Do you have, or experience, any of the following?

Yes	No		
☐	☐	Medication allergies	If yes, what:_____
☐	☐	Seasonal allergies	
☐	☐	Latex, Chemical	If yes, what:_____
☐	☐	Other	

Do you feel you are:

Yes	No	
☐	☐	Prone to infection

Constitutional

Over the past year, have you experienced:

Yes	No	
☐	☐	Weight loss?
☐	☐	Weight gain?
☐	☐	No change in weight?

If weight loss or gain, approximately how many pounds?
for example (30 lbs.)

+			lbs.	-			lbs.

Have you recently (within this past year) experienced any of the following?

Yes	No	
☐	☐	Fever
☐	☐	Chills
☐	☐	Night sweats

Physician use only)

Intake Questionnaire

Review of Systems Continued

Physician use only)

ENT & Mouth

Have you recently (within this past year) experienced any of the following?

Yes	No	
☐	☐	Nasal allergies
☐	☐	Trouble breathing through nose
☐	☐	Sinus infection
☐	☐	Hearing loss/hearing aids
☐	☐	Ringing in ears/tinnitus

Eyes Do you:

Yes	No	
☐	☐	Wear glasses / contacts
☐	☐	Have visual problems

Cardio-Vascular

Have you ever experienced any of the following?

Yes	No	
☐	☐	Heart attack
☐	☐	Chest pain
☐	☐	Palpitation
☐	☐	Congestive heart failure
☐	☐	High blood pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Irregular heart beat/atrial fibrillation
☐	☐	Pacemaker

Respiratory

Do you have, or experience, any of the following?

Yes	No	
☐	☐	Asthma
☐	☐	Emphysema/COPD
☐	☐	Chronic cough
☐	☐	Shortness of breath

Gastro-Intestinal

Have you recently (within this past year) experienced any of the following?

Yes	No	
☐	☐	Heartburn
☐	☐	Abdonimal Pain
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Irribable Bowel Syndrome
☐	☐	Reflux

Urinary

Have you experienced any of the following?

Yes	No	
☐	☐	Nighttime urination
☐	☐	Stones
☐	☐	Uncontrolled urination
☐	☐	Blood in urine

Musculoskeletal

Have you ever experienced any of the following?

Yes	No	
☐	☐	Joint swelling
☐	☐	Joint redness
☐	☐	Muscle or bone pain (unknown cause)
☐	☐	Arthritis
☐	☐	Fibromyalgia
☐	☐	Skin rash
☐	☐	Breast lumps

Intake Questionnaire

Review of Systems Continued

Skin / Breast

Over the past year, have you experienced?

Yes	No	
☐	☐	Mammography / breast exam
☐	☐	Dry skin

Neurology

Have you ever experienced any of the following?

Yes	No	
☐	☐	Headache (frequent / severe)
☐	☐	Loss of consciousness
☐	☐	Numbness (frequent / prolonged)
☐	☐	Weakness
☐	☐	History of stroke/TIA
☐	☐	Seizure
☐	☐	Fatigue
☐	☐	Dizziness
☐	☐	Pain in feet or legs
☐	☐	Burning in feet or legs
☐	☐	Head Injury

Psychiatric

Have you ever experienced, or received treatment for any of the following?

Yes	No	
☐	☐	Depression
☐	☐	Anxiety/panic attacks
☐	☐	Psychiatric treatment

Endocrine

Do you have, or experience, any of the following?

Yes	No	
☐	☐	Thyroid problems
☐	☐	Diabetes
☐	☐	Treatment with steroids
☐	☐	Low blood sugar

Hematological

Have you ever experienced any of the following?

Yes	No	
☐	☐	Anemia
☐	☐	Abnormal blood count
☐	☐	Hepatitis C

Physician use only)

Intake Questionnaire

Have you had any injuries, including head injury or loss of consciousness? (If yes, lease list below with year)

Congratulations, you are finished. If there are any comments or suggestions you may have regarding your reasons for today's office visit; please provide it in the space below. Again, thank you for your time and effort. It is a pleasure to serve you.

Your comments and suggestions

ROS Summary - PHYSICIAN USE ONLY