TEXAS SLEEP MEDICINE

Patient Questionnaire

Name: _____

Date of Birth: _____ Today's Date:_____

What is your main sleep complaint and how long has it occurred?

_____

Have you ever had a sleep study before? If yes, please tell us when and where it occurred.

_____

Please check all the boxes that currently apply to you:

Neurological	Gastrointestinal	Ear/Nose/Throat
❑ Headaches ❑ Dizzy Spells ❑ Seizures ❑ Fainting ❑ Memory Loss ❑ Numbness/tingling ❑ Weakness	❑ Difficulty swallowing ❑ Nausea or vomiting ❑ Constipation ❑ Bloody or black stools ❑ Abdominal pain ❑ Heartburn ❑Vomiting blood	❑ Hearing loss ❑ Ear aches ❑ Sinus pain ❑ TMJ pain or clicking (jaw) ❑ Nasal congestion ❑ Nasal drainage ❑ Nose bleeds ❑ Mouth sores ❑ Hoarseness
Heart	**Musculoskeletal/Skin**	**Eyes**
❑ Chest pain ❑ Palpitations ❑ Swelling of feet	❑ Joint pain/swelling ❑ Muscle pain ❑ Back pain ❑ Neck pain ❑Rash	❑ Visual change ❑ Eye pain
Lung	**Allergy/Immunology**	**Endocrine**
❑ Shortness of breath ❑ Coughing ❑Coughing up blood ❑ Wheezing	❑ Seasonal allergies ❑ Eczema	❑ Excessive thirst ❑ Heat/cold intolerance ❑ Hot flashes
Kidney/Bladder	**General**	**Blood**
❑ Urinate frequently ❑ Painful urination ❑ Blood in urine ❑ Difficulty urinating ❑Urinary incontinence ❑ Sexual Difficulty	❑ Fever ❑ Night sweats ❑ Loss of appetite ❑ Unexpected weight loss ❑ Weight gain ❑ Irritability	❑ Anemia ❑ Easy bruising/bleeding **Psychiatric** ❑ Anxiety/nervousness ❑ Depression/sadness

Current Weight: _____lbs

Height: _____ft _____inches

Weight **One Year** Ago: _____lbs

Weight **Five Years** Ago: _____lbs

Allergy	Medication	Allergic Reaction
1)		
2)		
3)		
4)		

Have you ever had any of the following medical conditions? (Check all that apply)

Heart Disease	Gastrointestinal	Neurology
❑ Heart failure ❑ Heart attack ❑ Angina ❑Atria fibrillation ❑ Arrhythmia ❑ High blood pressure	❑ Liver disease ❑ Stomach ulcers ❑ Reflux disease ❑ Colitis	❑ Stroke or TIA's ❑ Parkinson's disease ❑ Seizure ❑ Spinal cord injury ❑ Head injury
Lung Disease	**Ear/Nose/Throat**	**Endocrine**
❑COPD/Emphysema ❑ Chronic bronchitis ❑ Asthma ❑ Pneumonia	❑ Chronic sinusitis ❑ Season allergies ❑Nasal surgery ❑ Hard/soft palate surgery ❑ Tonsillectomy Age:_____	❑ Diabetes: Type: ____ ❑Thyroid disease
Musculoskeletal	**Kidney/Bladder**	**Miscellaneous**
❑ Rheumatoid arthritis ❑ Lupus ❑ Osteoarthritis ❑ Fibromyalgia ❑ Spine/Back surgery	❑ Kidney failure ❑ Enlarged prostate **Psychiatric** ❑ Depression ❑ Anxiety ❑ Dementia ❑ Chemical dependency	❑ Cancer Type:_____ ❑ Peripheral vascular disease ❑ HIV/AIDS ❑ Anemia ❑ Blood clots ❑ Major trauma:_____ ❑ Chronic fatigue syndrome ❑ Leukemia or lymphoma

Please list any past surgeries or illnesses not mentioned above:

Type of Surgery or Illness	Date

Place an X in the appropriate boxes if your family members have had any of the following conditions:

	Father	Mother	Siblings	Children
Cancer				
Diabetes				
High Blood Pressure				
Stroke				
Heart Disease				
Insomnia				
Narcolepsy				
Snoring				
Sleep Apnea				
Restless Legs				

Occupation:_____

What is your work schedule?_____

Marital status:
❒Single ❒ Domestic Partner
❒Married ❒Widowed
❒Separated ❒Divorced

Children:
❒None
❒Yes, but not living with me
❒Yes, living with me Ages: _____

Race: _____ Ethnicity: _____

Do you currently drink alcohol? ❒ Yes, how much _____ ❒No

Do you use tobacco products? ❒Yes, how much _____ ❒No/stopped last use _____ ❒No/never

Do you use marijuana? ❒Yes, how much _____ ❒No/stopped last use _____ ❒No/never

Do you use illicit substances? ❒Yes, which ones_____ ❒No/stopped last use_____❒No/never

Do you currently drink caffeinated beverages? ❒Yes ❒No

How many per day: Cans of Soda: _____ Cups of Coffee:_____ Cups of Tea:_____ Energy drinks _____

At what time of day/night do you have your last caffeinated beverage? _____

Please complete the schedule below:

Days of the week	Time you go to bed	Time you get out of bed
On weekdays/work days, what is your current schedule?		
On weekend/days off, what is your current schedule?		
What would be your ideal schedule?		

Do you eat, argue, worry, write, and/or read in bed?❒Yes ❒No

If yes, specify:_____

Do you have difficulty falling asleep? ❒Yes ❒No

If yes, how long does it take? _____ # minutes/hours ____# of nights weekly

Do you have several awakenings during the night? ❒Yes ❒No

If yes, _____ # of times nightly _____ # of nights weekly

Why do you awaken?_____

Do you have extended periods of wakefulness during the night? ❒Yes ❒No

If yes, _____ # minutes/hours _____ # of nights weekly

Do you awaken too early in the morning and stay awake? ❒Yes ❒No

If yes, at what time_____a.m. _____ # of times weekly

Did you have any sleep problems as a child? ❒Yes ❒No

If yes, specify: _____

For the following situations, indicate the chance of dozing or falling asleep (not feeling tired) by using the scale below:

0 = would never doze 2 = moderate chance of dozing
1 = slight 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 meeting or a theatre)	_____
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 lunch without alcohol	_____
In a car while stopped for a few minutes in traffic	_____
Total =	_____

Have you ever had an accident or near miss because of dozing while driving? ❑ Yes ❑No

If yes, when and describe:_____

Place an X in the most appropriate box

Never - it does not occur
Occasionally – occurs one or more times a week
Rarely – occurs monthly
Frequently – almost daily

Question	Never	Rarely	Occasionally	Frequently
Do you currently have intense nightmares or night terrors?				
Do you ever have exceptionally vivid dreams while falling asleep?				
Do you have sudden muscle weakness when you laugh or are angry?				
Do you feel paralyzed as you are falling asleep or waking up?				
Do you currently grind your teeth at night?				
Do you currently talk in your sleep?				
Do you currently walk in your sleep?				
Do you awaken to urinate?				
Do you currently have incontinence of urine during sleep?				
Does your bed partner complain about your excessive moving?				
Do you awaken yourself by kicking your legs?				
Has your bed partner ever complained of leg kicks?				
Do you have a restless sense of discomfort in your legs while resting or before falling asleep?				
Have you been told you stop breathing during sleep?				
Do you snore?				
Do you ever awaken gasping for air?				
Do you awaken with a dry mouth?				
Do you awaken with nasal congestion?				
Do you awaken with morning headaches?				
Do you awaken with a sore throat?				
Do you have night sweats?				
Do you have heartburn at night?				
Do you feel unrefreshed after sleeping?				
Are you ever confused in the morning?				
Do you feel depressed?				
Do you have problems with memory/concentration?				
Do any of your children and/or pets sleep in the bedroom with you?				

Please list all list the medications you currently take (including over-the-counter):

Medication	**Dose**(ie, mg strength)	**Times Per Day**	**Prescribing Doctor** (if prescription)

Please list the names/address/phone numbers of the doctors you would like to receive reports from our clinic:

Name	**Address**	**Phone Number**

I hear by give permission to Texas Sleep Medicine to release my medical records to the above providers. This information may be disclosed by fax, by mail, or by oral communication. I understand that my records are protected and cannot be disclosed without this written consent. I also understand that I may revoke this consent by written communication except to the extent that action has already been taken in reliance on it (i.e. information already disclosed). My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand. This authorization shall remain valid until revoked by me in writing.

_____ _____

Signature Date