NEW PATIENT QUESTIONNAIRE

These questions should be answered by **you** and **your bed partner** (or **anyone who may have observed you sleeping**):

a) Answer them in relation to the last 6 months, unless otherwise specified.
b) A "weekday" should be thought of as any day that you routinely work.
c) ***If you are engaged in shift work or have any type of unusual sleep/wake schedule, "day" and "night" should be interpreted as your major wake and sleep periods respectively.***

MY MAIN SLEEP COMPLAINT INVLOLVES:

☐ trouble sleeping at night ☐ being sleepy all day ☐ unwanted behaviors during sleep ☐ other_____

PLEASE CHECK THE SYMPTOMS BELOW THAT YOU EXPERIENCE OR THAT OTHERS HAVE OBSERVED:

- **DURING and/or WHILE FALLING ASLEEP:**

☐ snoring	☐ gasping	☐ pauses in breathing	☐ choking	☐ snorting	☐ mouth breathing
☐ wheezing	☐ coughing	☐ shortness of breath	☐ racing heart	☐ acid reflux	☐ frequent awakenings
☐ urination	☐ sweats	☐ frequent pain	☐ nightmares	☐ vivid dreams	☐ grinding/clenching teeth
☐ sleep walking	☐ sleep talking	☐ sleep eating	☐ sleep terrors	☐ clockwatching	☐ acting out dreams
☐ bed-wetting	☐ seizures	☐ hallucinations	☐ paralysis	☐ leg cramps	☐ repetitive behaviors
☐ restlessness	☐ arm/leg jerks	☐ difficulty falling asleep	☐ mind/racing	☐ worrying	☐ difficulty staying asleep

- **UPON AWAKENING and/or ARISING FROM SLEEP:**

☐ clockwatching	☐ arm/leg jerks	☐ difficulty falling asleep	☐ mind/racing	☐ worrying	☐ difficulty staying asleep
☐ headaches	☐ dry mouth	☐ drooling	☐ dizziness	☐ sore throat	☐ nausea/vomiting
☐ acid reflux	☐ grogginess	☐ feeling unrefreshed	☐ leg cramps	☐ hallucinations	☐ paralysis

- **WHILE MAINTAINING WAKEFULNESS DURING THE DAY:**

☐ fatigue	☐ sleep attacks	☐ decreased libido	☐ inattentive	☐ forgetfulness	☐ excessive sleepiness
☐ irritability	☐ anxiety	☐ depressed mood	☐ restless legs	☐ accidents	☐ weakness with emotion

CIRCADIAN RHYTHM: "If left to my natural preference (no work, no school, etc.), I would naturally start to get sleepy around _____ and naturally start to wake up around _____.

LIST ALL MEDICATIONS (prescribed by a doctor or non-prescribed (Unisom, Sominex, Vivarin, Melatonin, etc.) that you have ever taken **for your sleep problems** including herbal, holistic, or natural medications.

Medication for Sleep	**Dose**	**Times Daily**	**Helpful?**	**Date Started**	**Use It Now?**	**Date Stopped?**	**Prescribing Doctor**

EPWORTH SLEEPINESS SCALE Use the scale below to choose the most appropriate number for each situation.		
Scale	**Situation**	**Chance of Dozing**
0 – would never doze 1 – slight chance 2 – moderate chance 3 – high chance	Sitting & Reading	
	Watching TV	
	Sitting inactive in a public place (i.e.: theater)	
	As a car passenger for an hour without a break	
	Lying down to rest in the afternoon	
	Sitting & talking to someone	
	Sitting quietly after lunch without alcohol	
	In a car, while stopping for a few minutes in traffic	
	Total Score	0

MEDICAL/SURGICAL HISTORY: Briefly list all the health issues or complaints you currently have or previously have had and any treatments for those issues/complaints

Review of Systems	Type of Problem/Treatment	Date	Treating Physician, Clinic, or Hospital
Respiratory (asthma, COPD, etc.)			
Opthalmologic (blurred vision, eyeglasses, etc.)			
Ears, Nose, Throat (rhinitis, vertigo, etc.)			
Heart, circulation, blood pressure (Cardiovascular)			
Stomach, digestive disorders (Gastrointestinal)			
Kidney, urological or sexual disorders (Renal/Urologic)			
Neurologic (head trauma, convulsions, etc.)			
Psychiatric/Psychological (depression, anxiety, etc.)			
Endocrine (Thyroid, diabetes, etc.)			
Orthopedic (accidents, bone fracture, dislocations, etc.)			
Pain (sciatica, chronic, etc.)			
Inflammatory (Rheumatoid arthritis, Crohn's, etc.)			
Surgical operations (e.g. tonsillectomy, nasal surgery, hysterectomy, etc.)			
Other conditions			

NAME ALL MEDICATIONS you are currently taking (prescribed or otherwise): **Including herbal, holistic, natural medications, etc.**

Current Medication(s)	Dose	Times Daily	Reason	How Long Used?	Prescribing Doctor

ALLERGIES: MEDICATION(S): _____ REACTION(S):_____

TRY TO BE SPECIFIC AND RATE YOUR ANSWER BASED ON AN AVERAGE NIGHT:

What time do you usually go to bed? _____ ☐am ☐pm

How long does it usually take you to fall asleep after deciding to go to sleep? _____ minutes

How many times do you wake up during a typical night? _____ times

What are the total hrs. of sleep that you usually get at night?

_____hours _____minutes

What time do you usually arise for the day? _____

How many naps do you take per week _____ ; and for how long (on average)? _____hours _____ minutes

LIST AMOUNTS OF BEVERAGES/SUBSTANCES BELOW YOU CONSUME: (If not used daily, list in the far right column the average per week)

Beverage/Substance	Daily	After 6:00 pm	Weekly
Cups of coffee			
Decaffeinated coffee (cups)			
Tea (glasses or cups)			
Carbonated drinks (cans/bottles)			
Beer, wine, liquor (cans/drinks)			
Recreational drugs (list below)			

DO YOU CURRENTLY SMOKE? ☐ yes ☐ no

If no, but you smoked in the past, how long has it been since you stopped? _____

For how many years did (have) you smoke(d)? _____

How many (note type of usage) cigarettes, cigars, or pipefuls of tobacco do (did) you use daily? _____

FAMILY HEALTH HISTORY: For each family member, write current age or age at death, present state of health (good, fair, poor) or cause of death, as well as sleep problems (snoring, insomnia, sleepiness, etc.) and major illnesses.

Relationship	If Living, Age / Health	If Deceased, Age/ Cause	Sleep / Medical Problems
Father			
Mother			
Spouse			
Brother(s)			
Sister(s)			
Children			

OCCUPATION: _____

TREATING HEALTH CARE PROVIDERS

List name, address, and phone number of primary care physician.	List name, address, and phone number of treating physician (if not your primary care physician).

Use the space below for additional comments that you may wish to make about your health, or intake of drugs, medicines, or alcohol.