Madisonhealth
Sleep Lab

Name: _____

Date of Birth: _____

Date of Service: _____

Height:_____Weight:_____Neck:_____

New Patient Adult Sleep Medicine Questionnaire

Epworth Sleepiness Scale				
How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Use the scale below to choose the most appropriate number for each situation. 0 = would **never** doze 1 = **slight** chance 2 = **moderate** chance 3 = **high** chance				
Situation:	**Chance of Dozing**			
	0	**1**	**2**	**3**
Sitting and reading				
Watching TV				
Sitting inactive in a public place (e.g., movie theater or meeting)				
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				

In your own words, please describe the main reason for coming to clinic today/Sleep Study:

_____

_____

Have you had a sleep study or sleep evaluation before? If so, specify when and where:

_____

Symptom Checklist

Fatigue/Sleepiness	**Yes**		**No**
I struggle to stay awake or feel tired during the day.			
I have fallen asleep while driving.			
I have difficulty with memory or concentration.			
Obstructive Sleep Apnea (OSA)			
I snore or have been told I snore.			
I have experienced choking, shortness of breath, or gasping during sleep.			
I avoid sleeping on my back.			
I struggle with nasal congestion.			
I experience leg swelling.			
I wake at night to urinate.			
Someone in my family has sleep apnea.			

Sleep Hygiene	Yes	No
My bedtime is _____. My wake time is _____. I sleep_____ hours per night.		
I feel refreshed and rested when I wake in the morning.		
I struggle to fall asleep. What prevents you from falling asleep? (racing thoughts, pain, restless legs, etc) How long does it take you to fall asleep?		
I have or currently use medications to help me fall sleep. Please list what you have/are taking:		
I wake multiple times during the night. If yes, list the reasons that wake you up:		
I nap intentionally or accidentally fall asleep during the day.		
I sleep in my bed at night.		
I watch television or use electronics in bed.		
I sleep with pets.		
I work in my bedroom.		
My bedroom is noisy or uncomfortable.		
Excessive Daytime Sleepiness (EDS)		
I have felt paralyzed while waking up or falling asleep.		
I have felt weakness in my face or knees when laughing or with strong emotion.		
I experience dream like hallucinations when falling asleep or waking up.		
I have a history of depression.		
I have chronic pain. What medications do you use for pain?		
Movement Disorders		
I have restlessness or discomfort in my legs at night.		
I have a history of sleep walking, sleep talking, sleep eating, or acting out in my dreams		
I clench or grind my teeth at night.		
I have nightmares.		

Medication List

Medication	Dose	How much do you take?

If you need more space, please use the back of this form.

Past Medical History

Mark all that apply:

- o Allergies
- o Anemia
- o Anxiety
- o Asthma
- o Atrial Fibrillation
- o Blood clots
- o Cancer, type: _____
- o COPD
- o CHF
- o Depression
- o Dementia
- o Diabetes
- o GERD
- o High cholesterol
- o High blood pressure
- o Migraine headaches
- o Heart attack or heart disease
- o Parkinson's disease
- o Renal disease
- o Restless leg syndrome
- o Seizure disorder
- o Sleep Apnea
- o Thyroid disorder
- o Other (*specify*):

_____

_____

Past Surgical History

Mark all that apply:

- o Angiography with stent
- o Appendectomy
- o Back surgery
- o CABG
- o Cardiac pacemaker
- o Gastric bypass/sleeve
- o Other
- o Hernia repair
- o Hip replacement
- o Knee replacement
- o Knee arthroscopy
- o Shoulder arthroscopy
- o Sinus Surgery
- o Septoplasty
- o Thyroidectomy
- o Tonsillectomy
- o Uvuloplasty

(*specify*): _____

_____

Social History

Circle one answer per following questions:

1) Do you use chewing tobacco, cigars, or cigarettes? Yes, currently No, I quit _____(year) Never

2) Do you alcohol? Yes, frequency: _____times/week, _____drinks/episode ____No

3) Do you drink caffeine? Coffee, tea, or soda: _____ drinks/day

4) Marital status: _____ Married ____ Single ____ Divorced ____ Widowed Other: _____

Occupation: _____

Family History

List health problems for each:

Mother: _____Deceased: yes / no

Father: _____Deceased: yes / no

Siblings: _____

Medical Providers

What Providers Are You Seeing Or Have You Seen?	Who	When
Primary Care Provider		
Cardiologist		
Pulmonologist		
Neurologist		
Oncologist		
Other Specialty		
Other Specialty		

Have you had any of the following tests

TEST	Where	When
Pulmonary Function Test (breathing tests)		
Echocardiogram (ultrasound of heart)		
Lab work in the Last 2 Years		
Overnight Oximetry Tests		
EKG		

Review of Systems

Please mark yes **ONLY** to those symptoms you have experienced in the **last 2 weeks**.

Pulmonary	Yes	Constitutional	Yes	Renal	Yes
Shortness of breath at rest		Fever		Blood in urine	
Shortness of breath with exercise		Night Sweats		Frequent urination at night	
Frequent Cough		Chills		Painful urination	
Waking up at night short of breath		Weight loss			
Wheezing				**Neurologic**	
Blood clots		**Gastrointestinal**		Migraines or headaches	
		Trouble swallowing		Numbness or tingling	
Cardiac		Heartburn		Dizziness	
Chest pain		Abdominal pain		Imbalance/unsteadiness	
Leg swelling		Nausea		Vertigo	
Heart racing or thumping		Vomiting			
Sleeping on 2+ pillows				**Psychiatric**	
		Musculoskeletal		Depression	
ENT		Muscle weakness		Anxiety	
Frequent sore throat		Joint pain		Poor Sleep	
Sinus infections		Joint swelling		Snoring	
Hay fever				Morning headaches	
Dry Mouth		**Hematology/Oncologic**		Sleep during the day	
		Anemia		Panic attacks	
		Bleeding tendency			