

## Sleep Clinical Intake Patient Questionnaire

Today's Date:		
Patient's Name:		Occupation:
DOB:	Age:	Marital Status:

Briefly describe your sleep problem:

List all medications you take, including over-the-counter medications:

List any allergies (include medication and food):

List any previous sleep studies:

Current weight: \_\_\_\_\_ lbs.    Weight 5 years ago was \_\_\_\_\_ lbs.  
 Height: \_\_\_\_\_    Neck Size: \_\_\_\_\_

What time do you usually go to bed?	_____ am/pm
What time do you usually get up?	_____ am/pm
How long does it take for you to fall asleep generally?	
How many awakenings do you average during the course of a typical night sleep?	
How many hours of sleep do you average each night?	

*Please answer Yes or No to the following questions.*

1.	Do you have periods during the day when you have a desire to nap?	Yes/No
2.	Do you take a nap?	Yes/No
3.	Do you feel refreshed upon waking in the morning?	Yes/No
4.	Have people told you that you snore or that you stop breathing during the night?	Yes/No
5.	Does your snoring disturb others?	Yes/No
6.	Do you sleep talk or sleep walk?	Yes/No

7.	Do you snack or eat during the night?	Yes/No
8.	Do you sleep with either a T.V., audio player or a light on?	Yes/No
9.	Do you have trouble <i>getting</i> to sleep?	Yes/No
10.	Do you have trouble <i>staying</i> asleep?	Yes/No
11.	Do you feel worried, anxious or nervous about getting a good night's sleep?	Yes/No
12.	Do you experience creeping, crawling or aching feelings in your legs or the inability to keep your legs still while sitting or while lying in bed?	Yes/No
13.	Do you move around in your sleep?	Yes/No
14.	Do you dream frequently?	Yes/No
15.	Do you hardly ever dream?	Yes/No
16.	Have you ever experienced weakness in any part of your body at times of extreme laughter, sadness or excitement?	Yes/No
17.	What position do you prefer to go to sleep in?	Yes/No
18.	What position are you in upon awakening?	Yes/No

***Social History:***

Do you drink caffeinated beverages? yes/no How much in 24 hours? \_\_\_\_\_  
 Do you drink beer or wine? yes/no How much in 24 hours? \_\_\_\_\_  
 Do you drink liquor? yes/no How much in 24 hours? \_\_\_\_\_  
 Do you smoke any tobacco product? yes/no How much in 24 hours? \_\_\_\_\_

***Past History: (Med/Psych/Surg) (circle all that apply for yourself & family)***

Insomnia	Hypertension	ADD/ADHD	Tonsillectomy
Fibromyalgia	Cardiac Arrhythmia	Depression	Palate Surgery
Heartburn or Reflux	Heart Attack	Anxiety	Adenoidectomy
Morning Headaches	Cardiac Surgery	Seizures	Nasal Surgery
Diabetes	Heart Failure	Other: _____	Obesity Procedure
Other: _____	Stroke		

**ROS (office use only)**

**congestion**  
**dry mouth**  
**cough**  
**acid reflux**  
**muscle aches**  
**poor memory**  
**leg cramps**

**nocturia**

**bruxism**

**reviewed with patient**

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**NAME:**

**DATE:**

**The Epworth Sleepiness Scale** *(please read below and complete)*

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to the usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. 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:**

**Chance of Dozing:**

- 1) Sitting and reading. \_\_\_\_\_
- 2) Watching TV. \_\_\_\_\_
- 3) Sitting, inactive in a public place (e.g., movie theatre). \_\_\_\_\_
- 4) As a passenger in a car for an hour without a break \_\_\_\_\_
- 5) Lying down to rest in the afternoon, when permissible. \_\_\_\_\_
- 6) Sitting and talking to someone. \_\_\_\_\_
- 7) Sitting quietly after lunch without alcohol. \_\_\_\_\_
- 8) In a car, while stopped for a few minutes in traffic. \_\_\_\_\_