Dear Patient,

You have been scheduled for an appointment to evaluate your sleep problems. Your evaluation will start with an office consultation. To help ensure that we have accurate information about your sleep we request that you complete the attached questionnaire prior to your appointment. If possible someone who is familiar with your sleep should assist you in answering the questionnaire. That person is also welcome to accompany you to your clinic appointment. In some cases the physician who sees you will need to order a sleep study as part of your evaluation. Those plans will be made during your initial consultation.

Please remember to bring the completed questionnaire to your appointment.

Thank You,

Robert C. Hinkle, M.D., FAASM
Sleep Medicine
The Baton Rouge Clinic

Patient History

Name_____

Sex Male / Female (circle) Age _____ Height(in) _____ ____ Current Weight(lbs.)_____

Past Sleep Problems

Have you had a sleeping problem **diagnosed by a doctor** in the past? Yes_____ No_____

If yes, what was the problem? ___sleep apnea something else (please specify)_____

If yes, what treatment(s) was/were needed? _____

Did the treatment(s) help? Yes_____ No_____

Where was the diagnosis made and about when ?_____

Sleep Schedule and Sleep Hygiene

Do you keep a fairly regular sleep/wake schedule? Yes_____ No_____ if irregular, how much does your bedtime vary over a week? _____

What time do you usually go to bed on week days or days that **you work**? ___ ___: ___ ___ a.m. /p.m.(circle)

What time do you usually get up on week days or days that **you work**? ___ ___ : ___ ___ a.m. / p.m.(circle)

What time do you usually go to bed on week ends or days you **don't work**? __ ____ : ___ ___ a.m. / p.m.(circle)

What time do you usually get up on week ends or days you **don't work**? ___ ___: ___ ___ a.m. / p.m.(circle)

Do you usually feel well rested upon awakening? Yes_____ No_____ If not, how do you feel? _____

How many hours do you usually sleep?

Week days or days that **you work** _____ hours

Week days or days that you **don't work** _____ hours

Do you nap during the day? Yes_____ No____

If yes to above	Number of Naps per week	Average length (minutes)	Feel refreshed afterwards?
Weekdays (work days)	_____	_____	Y / N / a little better
Weekends (days not working)	_____	_____	Y / N / a little better

Do you read in bed? Yes_____ No____

Do you watch TV in bed? Yes_____ No____

Do you frequent look at your bedroom clock at night? Yes_____ No____

Do you have arguments in bed? Yes_____ No____

Do you eat in bed? Yes_____ No____

Do you worry in bed? Yes_____ No____

Do you currently do shift work? Yes_____ No____

Have you done shift work in the past? Yes_____ No____

If yes to the above 2 questions, do you have trouble sleeping when you are doing shift work?

If yes to above, what shift do you work Second Third Rotating (how? _____)

Yes_____ No____

Does your spouse perform shift work? Yes_____ No____

If yes to above please explain:_____

Do you share your bed with anyone? Yes_____ No____ I previously did, but they / I moved to another room _____

If yes to above please circle any who share your bed

Spouse/significant other Pet (what kind_____) Children (ages _____)

If yes to above, do any of them disturb your sleep? If yes, please explain _____

Please circle any adverse factors in your sleep environment

Too hot Too cold too much light noise (if so, please explain _____) frequent interruptions (what? _____)

Bed uncomfortable (if so, how _____) other factors: _____

Answer the following questions assuming "night" means your major sleeping time. I.E. if you are a shift worker and sleep during the day "night" = daytime sleep period

Do you often have trouble getting to sleep at night? Yes_____ No____ Are you sleepy when you go to bed? Yes_____ No____

What is the average number of minutes it takes you to fall asleep at night? _____ Minutes

If yes to above, please circle any of the following you have

Can't stop thinking about things frequent clock watching frustrated over inability to sleep sleep better in different environments (on vacation)

Do you think your sleep would be better if you could go to bed later (i.e. 2-3 AM) and wake up later (noon?) , i.e. are you a "night owl" Yes_____ No____

Do you often have awakenings during the night? Yes_____ No____

If yes to above, what is the average number of times per night you wake up? _____ Times per Night

If yes to above, why do you awaken (circle factors below or write out any unlisted)?_____

CIRCLE ANY FACTORS THAT YOU THINK MAY DISTURB OR PREVENT YOUR SLEEP: Pain (where? _____)

Heartburn Worry Children Leg kicking / movements Snoring Choking/gasping Coughing Night sweats Hot flashes

Need to use the bathroom Breathing difficulties Noises (what? _____) Bedpartner (snoring, kicking, etc.) Belly Cramping

On most nights, do you have long periods when you awaken and are not able to get back to sleep? Yes_____ No_____

If yes to above, how long are these periods of wakefulness when added together? _____ Minutes per night

Are you bothered by waking up too early and not being able to go back to sleep? Yes_____ No____If yes, what is the number of nights per week?_____

Movement

Do you awaken yourself by kicking your legs, or other sudden movements, during the night? Yes_____ No____

Has your bed partner every complained of your legs kicking, or other sudden movements, during the night? Yes_____ No____

Do you have a vague sense of discomfort or an unpleasant sensation in your legs which is relived **only by getting up, rubbing your legs, or moving**?

Yes____ No____ What time of the day does it typically come on? ___ ___ : ___ ___ a.m. / p.m.(circle one)

If yes, does it cause you difficulty with falling asleep? Yes_____ No____

Parasomnias

Did you have a sleep problem as a child? Yes_____ No____

If yes, describe_____

_____

Do you currently have frequent nightmares or night terrors Yes_____ No_____ If yes, how frequently?_____ per week/month/year (circle one)

Do you grind or clench your teeth at night? Yes_____ No____

Do you have morning jaw pain or has your dentist made you a mouthpiece for this? Yes_____ No____

Did you frequently wet the bed as a child? Yes_____ No____

Have you ever wet the bed as an adult? Yes_____ No____

Have you ever been told that you walk in your sleep? Yes_____ No____ Have you recently walked in your sleep Yes_____ No____

Have you ever been told you make unusual movements such as swinging arms about, acting out dreams, etc. During sleep? Yes_____ No____

Excessive Sleepiness

Do you feel sleepier **than the average person** during the daytime? Yes_____ No____

If yes to above, how long? _____ months/years (please circle one)

If yes to above, do you feel your sleepiness is a result of poor quality of nighttime sleep? Yes_____ No____

How likely are you to **doze off or fall asleep** in the following situations, **in contrast to feeling just tired**? This refers to your 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: **Please put a number value for each circumstance**.

0= would ***never*** doze
1=***slight*** chance of dozing
2= ***moderate*** chance of dozing
3 = ***high*** chance of dozing

Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place	_____
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 a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Have you ever felt sudden muscle weakness when you laughed, got angry, or when you told a joke? Yes_____ No____

If yes to above, describe_____

Have you ever been unable to move your body just as you were falling asleep or waking up? Yes_____ No____

If yes to above, describe_____

Have you ever had hallucinations just as you were falling asleep or waking up? Yes_____ No____

If yes to above, describe_____

Have you ever had a driving accident or a near miss accident as **a result of falling asleep or feeling sleepy at the wheel**?

If yes to above, describe_____

Respiration

Have people who have shared (or are sharing) your bedroom told you that you snore?

never_____ rarely (1-2 x/year)____ occasionally (4-8 x per year)_____ sometimes (1-2 x per month)____

Often (1-2 times per week)_____ Usually (3-5 times per week)_____ Always (every night)____ I don't know____

Duration _____months/years(circle)

Can your snoring be heard through closed doors or through a wall? Yes_____ No_____

Have you been told by other people that you gasp, choke, or snort while you are sleeping?

never_____ rarely (1-2 x/year)____ occasionally (4-8 x per year)_____ sometimes (1-2 x per month)____

Often (1-2 times per week)_____ Usually (3-5 times per week)_____ Always (every night)____ I don't know____

Have you been told that you stop breathing during sleep? Yes_____ No_____

If yes, to how often do you stop breathing during your sleep?

never_____ monthly_____ weekly_____ daily_____

Do you wake up with morning headaches? Yes_____ No_____

never_____ monthly_____ weekly_____ daily_____

Do you have bloodshot eyes with these headaches? Yes_____ No_____

Do you awaken with a dry mouth or sore throat?

never_____ monthly_____ weekly_____ daily_____

Do you wake with a choking or gasping sensation or awaken your self snoring?

never_____ monthly_____ weekly_____ daily_____

Do you have **drenching** night sweats (drench pillow or sheets)? Yes_____ No_____

Does sleep position affect your snoring? Yes_____ No_____

If yes to above, in which sleep position do you snore most loudly (pick one)?

Back_____ on right side_____ on left side_____ stomach_____ other

Do you have, difficulty breathing through your nose Yes_____ No_____

If yes to above, please describe circle any associated symptoms you have

Nasal stuffiness runny nose itchy eyes or ears runny nose around smoke/strong smells/perfumes allergies

Have you ever had surgery on your upper airway (tonsillectomy, sinus operation, etc.)? Yes_____ No_____

If yes to above, please describe_____ when? _____

Have you had any weight loss surgery? Yes_____ No_____

If yes to above, please describe_____ when? _____

Please recall your weight history: N/A if not applicable

Weight at age 20 _____lbs.

Weight at age 30 _____lbs.

Weight at age 40 _____lbs.

Weight at age 50 _____lbs.

Weight at age 60 _____lbs.

Heaviest Weight _____lbs. Age at heaviest weight_____years

Have you attempted to diet? Yes_____ No_____ have you tried weight loss medicatons? Yes_____ No_____

Medications and Drugs

Do you have any allergies or adverse reactions to medications? Yes_____ No_____

If yes to the above, which medications cause reactions and what is the reaction?

Name Reaction when?

A. _____

B. _____

C. _____

Please list below the name and dose of all medications you are taking and state how often and for what reason you take each one. If you take more than 6 please continue in the continuation section at the end. **Please include frequent over-the-counter medications and alternative medications or herbal remedies.**

Name Dose Times of day For What Reason

A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

G. _____

H. _____

I. _____

Medical and Surgical History

Please list or circle your current medical problems, such as high blood pressure, heart disease, stroke, lung disease, etc. and surgeries over last 10 years (if you need more than 9 lines please continue in the continuation section at the end.)

High blood pressure Acid Reflux Head injury (with unconsciousness or side effects) Stroke Heart attack Diabetes Ever had a seizure Thyroid gland problems Anemia Kidney Problems

A._____

B._____ _____

C._____

D._____

E._____

F._____

G._____

H._____

I._____

Psychological History

Do you feel depressed?

never_____rarely_____occasionally_____frequently_____always_____

Do you feel depressed now? Yes_____ No_____

Have you had a personality change? Yes_____ No_____

If yes to the above, please describe_____

_____

Have you ever seen a psychiatrist or any other type of counselor? Yes_____ No_____

If yes to the above, are you currently seeing a psychiatrist or a counselor? Yes_____ No_____

Please circle any of the following symptoms that you have had over the last two weeks

a. Felt sad frequently?
b. Lost interest in things (hobbies/activities) you used to do for fun?
c. Felt guilty about anything?
d. Have a low energy level?
e. Difficulty with concentration?
f. Had appetite changes (increased or decreased)?
g. Felt like doing little?
h. Felt like killing yourself?

Do you consider yourself to be under a great deal of stress on most days? Yes_____ No_____

If yes to above, what is this from? _____

Social Habits

Have you ever smoked cigarettes? Yes_____ No_____

Do you currently smoke cigarettes? Yes_____ No_____

If you previously smoked, when did you quit?_____

If you are a smoker or previously smoked, give an estimate of average packs of cigarettes/day while you were smoking _____, and Number of years of cigarette smoking _____ total

Have you ever smoked cigars? Yes_____ No_____ Currently? Yes_____ No_____

Have you ever chewed tobacco? Yes_____ No_____ Currently? Yes_____ No_____

Have you ever smoked a pipe? Yes_____ No_____ Currently? Yes_____ No_____

Please fill the chart below	cups/day	What times of day?
Caffeinated Coffee	____/_____	_____
Decaffeinated Coffee	____/_____	_____
Caffeinated Soft Drinks	____/_____	_____

Do you currently smoke marijuana or take any other mood altering illicit drugs? Yes_____ No_____

If yes to the above, what and how often?_____

Do you currently drink alcohol? Yes_____ No_____

If yes to the above, on the average, how many alcoholic drinks (1 glass of wine, 1 shot of liquor, or 1 beer is 1 drink) do you take on:

weekdays (working days) _____per day____ type of liquor _____

weekend days (non working days) _____per day____ type of liquor _____

Have you ever felt annoyed by others when they have expressed concerns regarding your drinking? Yes_____ No_____

Have you ever felt guilty about your drinking? Yes_____ No_____

Have you ever had the need to drink in the morning as an eye-opener? Yes_____ No_____

Do you ever have a drink just before going to sleep? Yes_____ No_____

Have you ever felt the need to cut down on your alcohol? Yes_____ No_____

Current Occupation_____ Involves significant amounts of driving? Y / N Do you work with dangerous machinery? Y / N

What time do you start work on average?____ AM / PM What time do you end your work day? _____ AM / PM Do your work hours vary from day to day? Y / N

Family History

Do members of your immediate family (e.g., father, mother, brother, sister, children) snore? Yes_____ No_____ (if so, please circle who snores)

Have members of your immediate family (e.g., father, mother, brother, sister, children) been diagnosed with sleep apnea? Yes_____ No_____

Do members of your immediate family have excessive daytime sleepiness? Yes_____ No_____

If yes to above explain_____

Do other members of your immediate family have any other problems with sleep? Yes_____ No_____

If yes to above explain_____

Do you have any other comments about your sleep? _____

_____

Thanks for filling out this questionarre! This helps me figure out how to help you best.