LEHIGH VALLEY HOSPITAL
SLEEP DISORDERS CENTER
17th & Chew Streets
Allentown, Pa 18104
610-969-4277
Patient Questionnaire

Date:_____ Date of Birth:_____

Name:_____ Home Phone:_____

Address:_____ Business Phone:_____

_____ Occupation:_____

_____ Sex: _____Male _____Female

Marital Status:_____ Height:_____ Weight:_____

Referring Physician's Name, Address, & Phone #:_____

_____

Family Physician's Name, Address, & Phone#:_____

_____

Do You have an Advance Directive (Living Will or Durable Power of Attorney)? YES / NO
If Yes, please provide a copy
If No, would you like information about Advance Directives? YES / NO

A. Describe your sleep/wake complaint (what actually brings you here?):_____
_____

1. Do you have trouble falling asleep? YES / NO
2. Do you have trouble staying asleep? YES / NO
3. Are you sleepy when you should be awake? YES / NO
4. Do you have abnormal movements/behaviors during sleep? YES / NO

B. The following questions are about <u>your</u> typical sleep schedule:

1. What time do you usually go to bed? _____ AM / PM
2. What time do you usually get out of bed? _____ AM / PM
3. How long does it take you to fall asleep?_____
4. How many times are you awakened from sleep each night?_____
   Why?_____
5. How many hours of sleep do estimate you get each night?_____
6. Are you a shift worker? YES / NO
7. Have you ever been a shift worker? YES / NO
8. What shift do you or did you work?_____
9. Is your spouse/bed partner able to sleep in the same bed with you? YES / NO

For office use only:

I have personally reviewed the entire contents of this questionnaire:_____
_____***FS*** _____***JHK*** _____***JPG*** _____***JS*** _____***RJS***

C. The following are questions about how sleepy you feel during your awake time:

How likely are you to doze off or fall asleep in the following situations (in contrast to just feeling tired)? This refers to your usual way of life in recent times. This is an average of how you do feel or would feel if you were doing these things.

Please 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**
Sitting and Reading	_____
Watching Television	_____
Sitting, Inactive in a Public Place (e.g. in a movie theatre or meeting)	_____
As a Passenger in a Car for One 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	_____

1. Do you feel unrefreshed upon awakening? YES / NO
2. Do you feel you are getting enough sleep at night? YES / NO
3. At what age did your sleepiness begin? teens 20s 30s 40s 50s 60s 70+
4. Is your daytime sleepiness mild, moderate, or severe?_____
5. Are you sleepy at work? YES / NO
6. Do you fall asleep at work? YES / NO
7. Do you feel sleepy when driving your car? YES / NO
8. Do you fall asleep when driving your car? YES / NO
9. How many times have you fallen asleep while driving?_____
10. After how many minutes of driving do you become sleepy?_____
11. How many times per week are you sleepy driving to/from work?_____
12. Have you had any car accidents due to sleepiness? YES / NO
13. Do you take naps during the day? YES / NO
14. Do you feel refreshed after a nap? YES / NO
15. Do you feel tired or fatigued during the day even though you are not sleepy? YES / NO
16. Would you classify your tiredness/fatigue as mild, moderate, or severe?_____
17. Which is worse, sleepiness or tiredness?_____
18. Is your daytime performance in work/recreation less efficient than you would like it to be? YES / NO
19. Are you having problems with your memory? YES / NO
20. Are you having trouble concentrating during the day? YES / NO

21. Do you have uncontrollable urges to fall asleep during the day? YES / NO

D. The following questions concern symptoms and behaviors related to sleep:

1. Have you ever been told that you snore loudly? YES / NO
2. Does your bed partner say that you stop breathing when you are sleeping? YES / NO
3. Does your bed partner snore? YES / NO
4. Do you sometimes wake up feeling like you are choking/gasping for breath? YES / NO
5. How many mornings per week do you awaken with a headache?_____
6. Are you a restless sleeper? YES / NO
7. Is your mouth dry upon awakening in the morning? YES / NO
8. Do you have "restless legs" when you lie down in bed before falling asleep? YES / NO
9. Have you ever been told that your legs twitch during the night? YES / NO
10. Do you walk in your sleep? YES / NO
11. Do you talk in your sleep? YES / NO
12. Do you grind your teeth during sleep? YES / NO
13. Do you wet the bed during sleep? YES / NO
14. Do you sweat excessively during sleep? YES / NO
15. Do you have frightening dreams or nightmares? YES / NO
16. Do you have night terrors or wake up screaming? YES / NO
17. How many times per week do you awake from sleep and eat something before returning to sleep?_____

E. The following questions deal with medical problems that can affect sleep:

1. Have you ever had a convulsion (e.g. fit, epilepsy, seizure)? YES / NO
2. Have you ever suffered a head injury? YES / NO
3. Do you feel depressed, sad, or "blue" during the day? YES / NO
4. Would you classify your depression as mild, moderate, or severe?_____
5. Do you frequently feel anxious or worried during the day? YES / NO
6. Are you unusually sensitive to heat or cold? YES / NO
7. If you are a man, do you have problems obtaining or sustaining a penile erection? YES / NO
8. If you are a woman, are your menstrual periods in any way abnormal or irregular? YES / NO
9. If you are a woman, are your pregnant? YES / NO
10. If you are a woman, are you past menopause (change of life) or are your having menopausal symptoms now? YES / NO
11. Have you ever been interviewed by a psychiatrist or clinical psychologist? YES / NO
    (please circle which type of doctor you have seen)

    Dr.'s Name:_____

12. Are your sleep complaints cyclical (occurring only in the evening, every 10 days, when you are away from home, etc.)? YES / NO

13. Do you have palpitations during the night? YES / NO
14. Do you have heartburn? YES / NO

    How many times per week?_____

15. Do you have generalized aching upon awakening? YES / NO
16. How often do you get up at night to urinate?_____

    How long does it take you to return to sleep?_____
17. Do you have arthritis, joint pain, or back pain which disturbs your sleep? YES /NO
18. Have you ever been told that you have fibromyalgia? YES / NO
19. How much weight have you gained in the past year?_____
20. What is your neck size?_____
21. Do you have nasal stuffiness? YES / NO
22. Do you have post-nasal drip? YES / NO
23. Do you have hallucinations or dream-like mental images when you are falling asleep? YES / NO
24. Do you feel paralyzed when falling asleep? YES / NO
25. Do you have attacks of sudden physical weakness or paralysis when laughing, angry, or in other emotional situations? YES / NO

E. Medication/Drug History:

Please list your current prescription medications (use a separate sheet if more space is needed):

Name of Medication	Dosage	Times per Day	Reason	Length of Time Used	Prescribing Physician

1. What non-prescription drugs do you use?_____

   _____

   _____
2. Do you take any stimulants (Ritalin, "uppers') during the day? YES / NO
3. Do you take any sedatives (barbiturates, "downers") during the day? YES / NO
4. Have you ever used narcotics (heroin, cocaine, etc.), marijuana, or other "street drugs"? YES / NO

   When was the last time?_____

F. Allergies

Drugs (e.g. aspirin, penicillin, sulfa, etc.): Please list Drugs and Explain Reaction.

_____

_____

_____

_____

Environment (e.g. pollen, dust, cats, etc.): Please list and Explain Reaction.

_____

_____

_____

_____

G. Alcohol, Tobacco, and Caffeine History:

1. How much alcohol (beer, wine, liquor) do you consume each week?

   _____Ounces _____# of Drinks

2. How much tobacco do you use per day?

   _____Packs _____Cigars _____Pipes _____Chew

3. How many servings of the following beverages do you consume?

	# Per Day	# after 6:00 pm
Regular Coffee		
Decaffeinated Coffee		
Regular Tea (Hot or Iced)		
Decaffeinated Tea (Hot or Iced)		
Soft Drinks (Pepsi, Coke, Etc.)		
Caffeine Free Soft Drinks		

G. Medical History:

1. What medical conditions are you currently being treated for?_____

   _____

   _____

2. Surgeries – Please list any past operations and approximate dates:

   _____

   _____

   _____

   _____

EAR, NOSE, AND THROAT: Do you have any of the following?

☐ Nasal Stuffiness/Congestion ☐ Chronic Mouth Breathing ☐ Dry Mouth

☐ Snoring ☐ Sinus Condition ☐ Nasal Polyps

☐ Tonsils/Adenoids Removed ☐ Sore Throat ☐ Nose Bleeds

☐ Ringing in the Ears ☐ Earaches ☐ Deafness

RESPIRATORY: Do you have any of the following?

☐ Shortness of Breath ☐ History of Pneumonia ☐ History of Tuberculosis

☐ Cough ☐ History of Asthma ☐ History of Blood Clots in Leg

☐ Sputum ☐ Wheezing

HEART DISEASE: Do you have any of the following?

☐ Angina ☐ Heart Attack ☐ High Blood Pressure

☐ Palpitations ☐ Chest Pain ☐ Leg Pain When Walking

☐ Rheumatic Fever ☐ Scarlet Fever ☐ Swelling of Ankles

☐ Phlebitis ☐ Bad Veins in Legs

GASTROINTESTINAL: Do you have any of the following?

☐ Trouble Swallowing ☐ Food Sticks in Throat With Swallowing

☐ Heartburn ☐ Ulcers ☐ Gall Stones

☐ Hepatitis ☐ Nausea/Vomiting ☐ Diarrhea

☐ Constipation ☐ Pain in the Abdomen ☐ Black Bowel Movements

☐ Hemorrhoids ☐ Blood in Bowel Movement

GENITOURINARY: Do you have any of the following?

☐ Kidney Stones ☐ Blood in Urine ☐ Urine Infections

☐ Frequent Urination ☐ Burning on Urination ☐ Trouble Starting Stream

☐ Awakening at Night to Urinate _____Times per Night

MUSCULOSKELATAL: Do you have any of the following?

☐ Arthritis ☐ Pain in Joints ☐ Swelling in Joints

☐ Chronic Back Pain ☐ Collapsed Vertebrae ☐ Curvature of the Spine

☐ Fibromyalgia ☐ Systemic Lupus

NEUROLOGICAL: Do you have any of the following?

☐ Seizures ☐ Epilepsy ☐ Migraines

☐ Dizziness ☐ Fainting ☐ Weakness/Numbness

☐ Stroke. . . . . if yes, resolved? ☐ Partially ☐ Completely

Describe areas affected by stroke:_____

ENDOCRINE: Do you have any of the following?

☐ Diabetes. . . . if yes, complications? ☐ Eyes ☐ Kidneys ☐ Neuropathy

☐ Low Blood Sugar ☐ High Blood Sugar

☐ Thyroid Condition: ☐ Overactive ☐ Underactive ☐ On Medication