PHYSICIANS' CLINIC
of Iowa, P.C.

SLEEP MEDICINE QUESTIONNAIRE

Date of first appointment _____ First Name _____ Last Name _____

Date of Birth _____ Age _____ Birthplace _____

Gender: ☐ Male ☐ Female Handedness: ☐ Right ☐ Left ☐ Ambidextrous

Main reason for your visit: _____

Describe briefly your present symptoms (quality, location, timing, other problems): _____

_____

_____

_____

Please list the names of other health care providers you have seen for this problem: _____

_____

Date symptoms began (approximate) _____ Diagnosis given? _____

Previous treatment for this problem (include physical therapy, surgery, and medications) _____

_____

_____

SLEEP HISTORY: Please check all that apply.

☐ Feel sleepy during the day
☐ Snore
☐ Awakened by your own snoring
☐ Wake up gasping for air
☐ Stop breathing while asleep
☐ Have restless sleep
☐ Have limb jerks while asleep
☐ Walk while asleep
☐ Talk while asleep
☐ Episodes of confusion
☐ Have vivid dreams/nightmares
☐ Have heartburn or gastric reflux
☐ Have morning headaches
☐ Have nighttime wheezing
☐ Wake up with a dry mouth
☐ Have an urge to move your legs
☐ Have a creepy, crawly feeling in your legs
☐ Usually dream during naps
☐ Feel muscle weakness with emotion (laughter, anger, etc)
☐ See or hear things when waking or falling asleep
☐ Feel like you can't move when waking or falling asleep

Do you work? ☐ Yes ☐ No (If no, please still complete your typical bedtime and rise time, as well as how long it typically takes you to fall asleep.)

What is your typical sleep schedule on **work** days? Bedtime: _____ AM / PM Rise Time: _____ AM / PM

What is your typical sleep schedule on **non-work** days? Bedtime: _____ AM / PM Rise Time: _____ AM / PM

How long does it take you to fall asleep on **work** days? _____ On **non-work** days? _____

If you have difficulty falling asleep, do you? ☐ Watch TV ☐ Read ☐ Toss & Turn ☐ Worry

Any other activities you do while trying to fall asleep? _____

How many times do you wake up at night? _____ How long does it take you to go back to sleep? _____

Do you wake up feeling tired? ☐ Yes ☐ No Do you nap or doze off during the day? ☐ Yes ☐ No

If you do nap or doze off during the day, how long and how often? _____ Are your naps refreshing? ☐ Yes ☐ No

EPWORTH SLEEPINESS SCALE: Please estimate your risk of falling asleep in the following situations, using the following scale:
0 = No chance of dozing 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (theater or meeting)	
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	
As a passenger in a car for an hour without a break	
TOTAL	

→

Have you had a sleeping problem diagnosed in the past? ☐ Yes ☐ No

If yes, what was the problem and what treatment was recommended? _____

Did the treatment help? ☐ Yes ☐ No Where was the diagnosis made? _____

CPAP/BIPAP HISTORY: *(if applicable)*

Which type of machine do you have? ☐ CPAP ☐ BIPAP ☐ Auto ☐ BIPAP-ASV ☐ VPAP Adapt

What is the current pressure setting? _____ Where do you get your equipment? _____

Are you using the machine every night? ☐ Yes ☐ No Do you find the machine helpful? ☐ Yes ☐ No

If not, please explain: _____

Do you have any of the following problems when using your machine?

☐ Snoring ☐ Bloating/Gas ☐ Nasal congestion ☐ Dry mouth ☐ Gasping for air ☐ Morning headaches

Other problems or complaints: _____

PAST MEDICAL HISTORY: *(please check all that apply and state when the problem started)*

☐ Headaches _____
☐ Seizures _____
☐ Back or Joint Problems _____
☐ Chronic Pain Syndrome _____
☐ Atrial Fibrillation/Flutter _____
☐ Anxiety _____
☐ Depression _____
☐ Drug or Alcohol Addiction _____
☐ Nasal or Throat Surgery _____
☐ Tonsillectomy _____

Other significant illnesses or infections: _____

_____

FAMILY HISTORY: Has any member of your family (not to include spouse or in-laws) ever had the following conditions. If yes, indicate family member.

			Family Member
☐ Yes	☐ No	Dementia	
☐ Yes	☐ No	Early Cardiac Death (<65 years old)	
☐ Yes	☐ No	Insomnia	
☐ Yes	☐ No	Narcolepsy	
☐ Yes	☐ No	Obstructive Sleep Apnea	

			Family Member
☐ Yes	☐ No	Parkinson's Disease	
☐ Yes	☐ No	Restless Leg Syndrome	
☐ Yes	☐ No	Seizures	
☐ Yes	☐ No	Sleep Walking	

Other conditions: _____

REVIEW OF SYSTEMS: Please check any new symptoms you have experienced in the last TWO WEEKS.

Constitutional
☐ Fever
☐ Chills
☐ Recent Weight Gain
☐ Recent Weight Loss

Endocrine
☐ Excessive Thirst
☐ Heat Intolerance
☐ Cold Intolerance

Skin
☐ Skin Rash
☐ Skin Lump

Eyes
☐ Blurry Vision
☐ Seeing Double

Ear/Nose/Throat
☐ Sore Throat
☐ Nasal Congestion

Cardiovascular
☐ Chest Pain or Discomfort
☐ Palpitations
☐ Leg Swelling

Respiratory
☐ Wheezing
☐ Shortness of Breath
☐ Frequent Cough

Hematological
☐ Swollen Glands in Neck
☐ Easy Bleeding - Recurrent

Gastrointestinal
☐ Abdominal Pain
☐ Nausea
☐ Vomiting
☐ Constipation
☐ Diarrhea
☐ Heartburn

Musculoskeletal
☐ Joint Pain
☐ Neck Pain
☐ Back Pain

Psychological
☐ Depression
☐ Anxiety

Genitourinary
☐ Urinary Loss of Control
☐ Urinary Frequency at Night
☐ Painful urination

Neurological
☐ Neurological Symptoms:

_____

_____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____