

Hunterdon Medical Center
Sleep Disorder Center
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Clinton Sleep Disorder Center
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Phone: (908) 735-3939
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CONFIDENTIAL PATIENT QUESTIONNAIRE

Name: _____ Date of Birth: _____ Today's Date _____

Address: _____

Phone# _____ Cell# _____

Referral Source:(Physician/ Self) If Physician, Name: _____

Phone # _____ Fax# _____

Age: _____ Years Height: _____ Feet _____ Inches Weight: _____ Lbs

What is your primary concern/ problem regarding your sleep?

How long have you had this concern/ problem?

____ Within the last month ____ 1- 6 months ____ 6 months to 2 years
____ Greater than 2 years ____ other time frame, (explain) _____

Rate the severity of your problem:

____ Moderate ____ Severe ____ the problem is only for others

Is the problem getting worse? ____ Yes ____ No ____ don't know

Not including your primary care physician, have you seen another physician for your sleep problem? ____ Yes ____ No

If yes, who was the physician? _____

When were you seen: _____

If you did see another physician regarding your sleep problem, what was the diagnosis?

Did you have a sleep study? ____ Yes ____ No Date of sleep study: _____

If yes, where did you have the study performed? _____

What treatment, if any, was recommended? _____

Was the treatment effective? ____ Yes ____ No

Sleep Hygiene

On weekdays/ workdays what time do you:

Go to bed? _____ Am/ Pm Get up? _____ Am / Pm

On weekends/ days off what time do you:

Go to bed? _____ Am/ Pm Get up? _____ Am/ Pm

Preferred sleep position: ___Back ___Side ___Stomach

___Chair/ recliner other: _____

Do you take naps during the day? ___Yes ___No

If yes how many naps/ daily _____

Are these naps refreshing? ___Yes ___No

How long do these naps last? ___# Minutes ___# of Hour's

Are any of the naps involuntary? ___Yes ___No

If yes, when do they occur during your day? _____

How often do they occur involuntarily? ___Daily ___Weekly ___Monthly

While in bed do you? ___Eat ___Read ___Write ___Watch TV

___Work/play on the computer ___Worry ___Argue

Other: _____

Do you have children or pets that sleep in the bed with you?

___Yes ___No, how often? ___Nightly ___Weekly ___Occasionally

Check any factors that disturb your sleep

___Heat ___Cold ___Light ___Noise ___Bed partner

Other _____

Insomnia

Do you have difficulty falling asleep? _____ Yes _____No

If yes, how long does it take to fall asleep? _____ Minutes _____hours

Do you wake up during the night? ___Never ___Occasionally

___Frequently ___Nightly

of occurrences/night: _____ # Of Minutes _____ # Of Hours _____

When you wake up at night do you: ___read ___watch TV

___Do work ___Eat ___Get on the computer

Do you wake up early in the morning and stay awake? ___Yes ___No

If yes, at what time? ___am # of times weekly _____

Did you have a sleep issues as a child? ___Yes ___No

If yes, please explain: _____

Sleep Disturbances

Some of the following questions will ask you to rate the frequency of certain symptoms. Please use the scale below as a guide when answering questions:

Frequently (F) = 1 or more times per week
 Occasionally (O) = 1 or more times per month
 Rarely (R) = the issue occurs less than above
 Never (N)

Please rate how often you or others have noted that you (check box):

| | F | O | R | N |
|--|---|---|---|---|
| Do you snore? Indicate the severity of your snoring using the following scale: ___ Grade 1: Heard only if you listen close to the face ___ Grade 2: Heard in the room ___ Grade 3: Heard just outside the open bedroom door. ___ Grade 4: Heard just outside the closed bedroom door. | | | | |
| Snore loudly enough that others complain | | | | |
| Awaken from sleep feeling short of breath, gasping or choking | | | | |
| Have you be told you stop breathing while asleep | | | | |
| Have headaches upon waking that improves within 2 hours | | | | |
| Experience other breathing problems at night | | | | |
| Awaken confused or disoriented | | | | |
| Sweat excessively at night | | | | |
| Awaken at night to urinate (# times/night_____) | | | | |
| Awaken with the sensation of a pounding heart or heart beat irregularity? | | | | |
| Experience heart burn at night | | | | |
| Awaken with nasal congestion | | | | |
| Feel sleepy or tired during the day | | | | |
| Awaken feeling unrested or unrefreshed | | | | |
| Get sleepy while driving | | | | |
| Have had a close call while driving due to sleepiness | | | | |
| Have had a car accident due to sleepiness | | | | |
| Become irritable or "crabby" during the day | | | | |
| Have trouble at work or school due to sleepiness | | | | |
| Experiencing a decrease in memory or ability to concentrate due to sleepiness | | | | |
| Fall asleep involuntarily, suddenly, or in awkward situations | | | | |
| Experience sudden weakness, buckling of knees, or facial heaviness when laughing, angry, scared, or crying | | | | |
| Feel totally unable to move (paralyzed feeling) upon awakening or falling asleep | | | | |
| Experience vivid dreamlike scenes, smells or sounds upon awakening or falling asleep. (Similar to hallucinations) | | | | |
| Find yourself doing complex tasks of which you were totally unaware (such as driving/ navigating without conscious awareness) | | | | |
| Have nightmares or night terrors | | | | |
| Act out your dreams | | | | |
| Sleepwalk | | | | |
| Other unusual behavior? Please explain _____ _____ | | | | |
| Do you eat in the middle of the night and are unaware of this behavior? | | | | |

| | | | | |
|--|------------------------------|-----------------------------|---|---|
| | F | O | R | N |
| Recurrently or rhythmically move, twitch or jerk your legs while asleep | | | | |
| Feel restlessness, agitation or discomfort in your legs before or at bedtime (if so, answer below) | | | | |
| Do you feel an overwhelming urge to move your legs | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Does this happen only in the evening | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Does this happen only when you are relaxed | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Does this get better if you change positions or walk around | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Does this disturb your sleep | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Do you wake up as a result of kicking your legs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| Does your bed partner complain about your kicking? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| How often do you experience this? _____ Nightly _____ Weekly _____ Infrequently | | | | |

EPWORTH SLEEPINESS SCALE

For the following situations, indicate the chance of dozing off or falling asleep by using the scale below:

0 = would *never* doze 1 = *slight* chance of dozing
2 = *Moderate* chance of dozing 3 = *High* chance of dozing

| Situation | Chance of dozing | | | |
|---|------------------|---|---|---|
| | 0 | 1 | 2 | 3 |
| 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 lunch without alcohol | | | | |
| In a car stopped for a few minutes in traffic (when driving) | | | | |

Total of all points _____

What would be an ideal sleep schedule for you?

Bedtime? _____ Am/ Pm Wake up time? _____ Am/ Pm

Mood

Do you ever feel depressed? _____ Yes _____ No
If yes: _____ Rarely _____ Occasionally _____ Frequently

Has your bed partner, friends commented about your mood changes?
_____ Yes _____ No

Do you (or others) feel that you have had a recent personality changes?
_____ Yes _____ No. If yes, specify: _____

Medical History

Please check the column (to the left of the condition) next to any condition that a physician diagnosed you with

| Cardiac/ Heart | | Digestive | | Neurology | | Psychiatry | | Lung | | Other | |
|--------------------------|---------------------------------|--------------------------|--------------------|--------------------------|--------------------------------|--------------------------|-----------------|--------------------------|------------------------|--------------------------|--|
| <input type="checkbox"/> | Arrhythmia | <input type="checkbox"/> | Acid reflux (GERD) | <input type="checkbox"/> | Headache | <input type="checkbox"/> | Alcoholism | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | Atrial fibrillation | <input type="checkbox"/> | Hiatal Hernia | <input type="checkbox"/> | Infection of brain/Spinal cord | <input type="checkbox"/> | Drug abuse | <input type="checkbox"/> | Bronchitis | <input type="checkbox"/> | Chronic pain |
| <input type="checkbox"/> | Coronary Artery Disease /Stents | <input type="checkbox"/> | Liver disease | <input type="checkbox"/> | Injury to brain/spinal cord | <input type="checkbox"/> | Depression | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | Chronic Fatigue Syndrome |
| <input type="checkbox"/> | Angina | <input type="checkbox"/> | Other digestive | <input type="checkbox"/> | Nerve damage | <input type="checkbox"/> | Suicide attempt | <input type="checkbox"/> | Allergies | <input type="checkbox"/> | Fibromyalgia |
| <input type="checkbox"/> | CHF- heart failure | <input type="checkbox"/> | | <input type="checkbox"/> | Seizure/ Epilepsy | <input type="checkbox"/> | Anxiety | <input type="checkbox"/> | Pulmonary Hypertension | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | Elevated lipids (cholesterol) | <input type="checkbox"/> | | <input type="checkbox"/> | Parkinson's | <input type="checkbox"/> | Panic Attacks | <input type="checkbox"/> | Other lung issues | <input type="checkbox"/> | Thyroid disease |
| <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | | <input type="checkbox"/> | Other brain or nerve disorder | <input type="checkbox"/> | ADHD | <input type="checkbox"/> | | <input type="checkbox"/> | Anemia or other blood related diseases |
| <input type="checkbox"/> | Stroke/ TIA | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | OCD | <input type="checkbox"/> | | <input type="checkbox"/> | Kidney disease |
| <input type="checkbox"/> | Heart attack | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | BPH |
| <input type="checkbox"/> | Other -cardiac | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | Cancer: What kind? _____ |

Additional comments about above noted answers:

Past Surgical History

Please list any surgical procedures and the approximate date of the procedure

| Date | Type of Surgery | Date | Type of Surgery |
|------|-----------------|------|-----------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have you had your Tonsils removed? ___Yes ___No. If yes, at what age? _____

Have you had nose or throat surgery? ___Yes ___No If yes, at what age? _____

Medications

Please provide a complete list of all medications you are now taking, with dose and frequency, or fill out the separate sheet attached with questionnaire. Also, list any drug allergies.

Family History

Check the appropriate boxes if your family members have had any of the following conditions

| Disease | Father | Mother | Brother | Sister | Children |
|---------------------|--------|--------|---------|--------|----------|
| Depression | | | | | |
| Diabetes | | | | | |
| Heart attack | | | | | |
| High Blood Pressure | | | | | |
| Stroke | | | | | |
| Insomnia | | | | | |
| Narcolepsy | | | | | |
| Restless legs | | | | | |
| Sleep apnea | | | | | |
| Snoring | | | | | |
| Other- please list | | | | | |

Social History

Marital Status: Single Married Domestic Partner Separated Divorced Widowed

Occupation: _____

Does your occupation involve shift work? _____

Are the shifts you work variable? Please list: _____

Does your occupation involve driving? Yes No If yes, _____ minutes _____ hours per day

Do you have children at home? None Grown Yes, Ages _____

Do you drink alcohol? Never Occasionally Frequently Alcoholic

Do you drink alcohol prior to going to bed? Yes No Occasionally Frequently Nightly

Do you smoke? Yes No Type: Cigarettes cigar pipe other

How much per day? _____ How many years? _____

When did you quit? _____ (Year)

Do you use recreational drugs? Yes No, Type _____

Frequency of drug use: Infrequent Weekly Daily _____

Do you currently drink caffeinated beverages? Yes No

If yes, please mark all that apply: Soft drinks-cans per day _____ Cups of coffee per day _____

Cups of tea per day _____ Other _____

Personal assessment of current health: Poor Fair Good Very Good Excellent

Weight change in the past 12 months: Yes No amount lost/ gained (circle): _____

Weight change in the past 5 years: Yes No amount lost/ gained: _____

The most you have ever weighed (non- pregnant) _____ pounds _____ what year(s)

Are you currently on a diet? ___Yes ___ No, if yes, what kind? _____

How long have you been dieting? ___Weeks ___ Months ___ Years

Have you attempted other weight loss techniques? ___Yes ___ No, if yes what types?

___Liquid diet ___Physician directed diet ___ Surgery ___ Hypnosis ___Acupuncture

Do you exercise? ___ Yes ___No, if yes, how often? ___Daily ___ Weekly ___Weekends ___Infrequent

What type of exercising do you do? _____

Review of Systems

Constitutional

Good general health Yes No
Loss of appetite Yes No
Fatigue Yes No
Weight loss Yes No
Fever Yes No
Other: _____

Eyes

Blurred vision Yes No
Double vision Yes No
Discharge Yes No
Vision changes Yes No
Other: _____

ENT/ Allergy

Trouble breathing (nose) Yes No
Night time congestion Yes No
Hoarse voice Yes No
Trouble swallowing Yes No
Swollen glands Yes No
Frequent infection Yes No
Frequent colds Yes No
Frequent hives Yes No
Seasonal allergies Yes No
Other: _____

Heart

Chest pain Yes No
Palpitations/ Irregular heartbeat Yes No
Leg swelling Yes No
Pain in legs Yes No
Atrial Fibrillation Yes No
Stroke / TIA Yes No
Elevated lipids Yes No
Hypertension Yes No
Heart attack Yes No
Heart Failure Yes No
Other: _____

Lungs

Chronic cough Yes No
Coughing up blood Yes No
Pain w/ breathing Yes No
Shortness of breath with mild exertion Yes No
Asthma Yes No
Bronchitis Yes No
Emphysema Yes No
Pulmonary Fibrosis Yes No
Pulmonary hypertension Yes No
Shortness of breath when laying flat Yes No
Other: _____

Gastrointestinal

Frequent nausea/ vomiting Yes No
Frequent Indigestion Yes No
Poor appetite Yes No
Frequent Diarrhea Yes No
Freq. Constipation Yes No
Bloating Yes No
Vomiting blood Yes No
Blood in stool Yes No
Abdominal Pain Yes No
Diverticulitis Yes No
Liver disease Yes No
Hiatal hernia Yes No
Other: _____

Genital/ Urinary

Blood in urine Yes No
Lack of sex drive Yes No
Freq. (Night) urination Yes No
Urinary incontinence Yes No
Males:
Trouble w/ erections Yes No
Prostate disease Yes No
Females:
Vaginal discharge Yes No
Irregular periods Yes No
No period Yes No
Other: _____

Musculoskeletal

Joint pain or swelling Yes No
Chronic back pain Yes No
Muscle pain or Weakness Yes No
Leg cramps Yes No
Other: _____

Neurological

Frequent headaches Yes No
Loss of strength Yes No
Loss of feeling Yes No
Fainting spells Yes No
Imbalance Yes No
Coordination Problems Yes No
Ringing in ears Yes No
Dizziness Yes No
Trouble walking Yes No
Numbness/ tingling Yes No
Seizures Yes No
Parkinson's disease Yes No
Infection of brain/ spinal cord Yes No
Injury to brain/ spinal cord Yes No
Nerve damage Yes No
Other: _____

Psychiatric

- Hallucinations Yes No
- Nightmares Yes No
- Feel depressed Yes No
- Feel nervous or tense Yes No
- Suicidal thoughts Yes No
- Mood swings Yes No
- Difficulty concentrating Yes No
- OCD - ADD – ADHD Yes No
- Alcoholism Yes No
- Drug abuse Yes No
- Anxiety Yes No
- Panic attacks Yes No
- Other: _____

Endocrine/ Other

- Heat intolerance Yes No
- Cold intolerance Yes No
- Excessive thirst Yes No
- Sexual dysfunction Yes No
- Hot flashes Yes No
- Uncontrolled diabetes Yes No
- Urinating frequently Yes No
- Arthritis/ chronic pain Yes No
- Back pain Yes No
- Chronic fatigue syndrome Yes No
- Fibromyalgia Yes No
- Excess sweating Yes No
- Thyroid disease Yes No
- Other: _____

Skin

- Rash Yes No
- Itching Yes No
- Hives Yes No
- Dry Skin Yes No
- Flushing Yes No
- Skin lesions Yes No
- Other: _____

Rest of review is otherwise negative Yes No

Entire questionnaire reviewed with patient on this date: _____

Patient signature: _____

Physician signature: _____

BED PARTNER QUESTIONNAIRE

Name of the Patient: _____ Date: _____

Name of the Person filling out the form: _____

I have observed this person's sleep: ___ Once or twice ___ Often ___ Every night

Check any behaviors observed while the person is sleep

- | | | |
|---|---|---|
| <input type="checkbox"/> Light Snoring | <input type="checkbox"/> Loud Snoring | <input type="checkbox"/> Twitching or kicking |
| <input type="checkbox"/> Choking | <input type="checkbox"/> Pause in Breathing | <input type="checkbox"/> Gasping |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Yelling or cursing |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Tongue biting | <input type="checkbox"/> violent tendencies |
| <input type="checkbox"/> Head banging | <input type="checkbox"/> Becoming rigid | <input type="checkbox"/> Other: _____ |

Please describe the checked sleep behaviors in detail. Include a description of the activity, the time of night it occurs and the frequency

Has this person ever fallen asleep during normal daytime activities or in dangerous situation? ___ Yes ___ No
If yes, please explain:

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PATIENT DEMOGRAPHIC QUESTIONNAIRE

Patient Name: _____

Address: _____

Date of Birth: _____ Social Security #: _____

Telephone #'s: Home _____ Cell #: _____

Work #: _____ Email: _____

Medical Insurance: _____ Address & Telephone #: _____

ID #: _____ Group # _____

Primary Care Physician: _____

PCP Tel. #: _____ Fax #: _____

Physician ordering test (Other than PCP): _____

Physician's Tel. #: _____ Fax #: _____

Emergency Contact Person: Name: _____ Relationship: _____

Telephone #'s: Home _____ Cell #: _____

Work #: _____ Other #: _____ - _____

** Due to HIPPA Privacy regulation, may we contact you at the above telephone numbers provided; to discuss anything pertaining to your evaluation, sleep study, etc. at Hunterdon Medical Center.

Signature of patient/ guardian

Legal Guardian or Closest Relative

Date

Relationship