General Questionnaire

Name:____ Date:_________________

Address:____

Home Phone:________________________________ Alternate number:________________________

Occupation:__________________________________ Age:_______ Height:_______ Weight:_______

Weight 6 months ago:__________ At age 20:__________ At your heaviest:_____________________

Referring Physician:___________________________ Family Physician:_______________________

1. In your own words, what is the reason you (or your doctor) contacted the Sleep Center?
   ____
   ____

2. How long have you had this problem?
   ____

3. Has anyone in your family had any type of sleep disorder?
   ____

4. What time do you usually try to fall asleep? _______________________________________

5. What time do you usually try to get out of bed? ____________________________________

6. Do these times vary? _____ If yes, please explain: _________________________________

7. How much time do you sleep at night? ____

8. How many times do you usually awaken each night? __________ Do you have difficulty returning to sleep? __________

9. How long are you awake altogether during the night? ______________________________

10. How often do you:

(when you are trying to fall asleep)	never	sometimes	occasionally	often
▪ have difficulty falling asleep?	☐	☐	☐	☐
▪ have thoughts racing through your mind?	☐	☐	☐	☐
▪ feel sad or depressed?	☐	☐	☐	☐
▪ have anxiety?	☐	☐	☐	☐
▪ worry about not being able to sleep?	☐	☐	☐	☐
▪ worry you won’t return to sleep after awakening?	☐	☐	☐	☐
(just prior to or during sleep)				
▪ have creeping, crawling or aching feeling in your legs?	☐	☐	☐	☐
▪ kick or twitch your legs?	☐	☐	☐	☐
▪ have unusual movements while asleep?	☐	☐	☐	☐
▪ wake up frequently?	☐	☐	☐	☐
▪ have trouble waking up in the a.m.?	☐	☐	☐	☐
▪ have restless or disturbed sleep?	☐	☐	☐	☐
▪ feel muscular tension?	☐	☐	☐	☐
▪ have any kind of pain or discomfort?	☐	☐	☐	☐
▪ wake up with chest pain?	☐	☐	☐	☐
▪ feel alert and energetic all day?	☐	☐	☐	☐
▪ snore loudly?	☐	☐	☐	☐
▪ wake up gasping for breath?	☐	☐	☐	☐
▪ sweat a lot during the night?	☐	☐	☐	☐
▪ wake up with a headache?	☐	☐	☐	☐
▪ wake up with a dry mouth?	☐	☐	☐	☐
▪ wake up sick to your stomach?	☐	☐	☐	☐
▪ walk in your sleep?	☐	☐	☐	☐
▪ fall out of bed while asleep?	☐	☐	☐	☐
▪ wake up screaming, violent or confused?	☐	☐	☐	☐
▪ wet the bed?	☐	☐	☐	☐
▪ grind your teeth while sleeping?	☐	☐	☐	☐

11. Have you ever had vivid dream-like scenes just as you are falling asleep? ___________
If yes, briefly explain: ____

12. Have you every felt paralyzed (could not move) just as you were falling asleep or waking up? ________ If yes, please explain: ____

13. How many naps do you take in a usual week? _______ length of naps? __________ Are they refreshing? _______

14. Do you have episodes of sudden muscular weakness when laughing, angry or in an emotional situation? ________ If yes, please explain: ______________________________

15. Have you had your tonsils or adenoids removed? _______

16. Can you breathe easily through your nose? ________

17. Have you ever had your nose broken or a facial fracture? ________

18. Do you have a problem with job performance due to sleepiness? ________

19. Do you have a problem driving due to sleepiness? ________

20. My sleep is frequently disturbed by: (check all that apply)

☐heat	☐choking	☐shortness of breath
☐cold	☐indigestion or heartburn	☐frightening dreams
☐light	☐hunger	☐cough
☐noise	☐thirst	☐chest pain
☐bed partner	☐children	☐pets
☐need to urinate	☐phone	☐asthma
☐creeping, crawling feelings in legs		

21. How much of the following fluids do you drink?

		During a typical day	Within 2 hrs of bedtime
Coffee:	caffeinated	__________ cups	__________ cups
	decaffeinated	__________ cups	__________ cups
Tea		__________ cups	__________ cups
Soda		__________ glasses	__________ glasses
Alcohol		__________ drinks	__________ drinks

22. How much tobacco do you smoke during a 24 hour period?
Cigarettes? __________
Cigars? __________
Pipe bowls? __________

23. Do you use any type of illicit drugs? _____ If so, what? ____________________________

24. Please list the name and dosage of all medications you take NOW or have taken in the last 30 days, including over the counter (non-prescription) medications.

____

____

____

____

____

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____

____

25. Please list any allergies or write NONE. ____

26. Please check any problem or illness you have now or have had in the past.

☐heart disease	☐headaches	☐depression	☐eye trouble
☐low blood pressure	☐fainting	☐mental problems	☐hearing trouble
☐high blood pressure	☐ringing of the ears	☐muscle cramps	☐pneumonia
☐heart attack	☐black outs	☐ulcers	☐meningitis
☐hernia	☐dizziness	☐prostate trouble	☐heartburn
☐back trouble	☐gout	☐kidney trouble	☐impotence
☐asthma	☐allergies	☐bladder trouble	☐cancer
☐bronchitis	☐seizures	☐arthritis	☐TB
☐thyroid condition			

27. Please list any illness not listed above, hospitalizations or surgeries you have had:

____

____

____

____

____

____

28. Do you wear CPAP or BiPAP at home? ____________ if yes what company issued your equipment? ______________

29. Do you use oxygen at home? ____________ if yes how many hours daily do you use it?

Anything you would like to add:

____
____
____
____