CHEST AND SLEEP INSTITUTE

NAME: _____ DATE: _____

ADDRESS: _____ AGE: _____ Date of Birth: _____

_____ PHONE: _____

MARITAL STATUS: _____ PATIENT # _____

OCCUPATION: _____ Wt._____ Ht. _____

Describe your sleep/wake complaint: _____

_____

_____

_____

What do you think would make it better? _____

_____

_____

List any prescribed medication or over-the-counter medication (i.e. Sudafed, Nyquil), either regularly or intermittently?

Name of Medication	Dose	Times	Purpose	Physician

Circle YES or NO or 11 in the blanks as appropriate.
Circle the answer NO if the problem is very infrequent.
Place an X beside any question you do not understand or can not answer by a simple yes or no.

A.

1. Do you feel like the quality of your sleep is unsatisfactory – that is, no matter how much sleep you get, you do not wake up feeling rested? YES NO

2. Do you have headaches at night or in the morning? YES NO

3. Do you have a persistent cough, nasal congestion or post-nasal drip that interferes with your sleep? YES NO

4. Do you sometimes feel that your personality has changed or that you often tend to be unusually irritable or just not yourself? YES NO

Key for answers

1	2	3	4	5
Never (strongly disagree)	**Rarely (disagree)**	**Sometimes (not sure)**	**Usually (agree)**	**Always (agree strongly)**

5. I am told I snore loudly and bother others. 1 2 3 4 5

6. I am told I stop breathing (hold my breath) in sleep. 1 2 3 4 5

7. I awake suddenly gasping for breath, enable to breathe. 1 2 3 4 5

8. I sweat a great deal at night. 1 2 3 4 5

9. I have high blood pressure (or once had it). 1 2 3 4 5

10. I have a problem with my nose blocking up when I am trying to sleep (allergies, infections). 1 2 3 4 5

11. My snoring or breathing problem is much worse if I sleep on my back. 1 2 3 4 5

12. My snoring or my breathing problem is much worse if I fall asleep right after drinking alcohol. 1 2 3 4 5

IN THE NEXT SECTION, PLEASE CIRCLE THE ITEM (NUMBERED 1-5) WHICH BEST MATCHES YOUR ANSWER.

Circle YES or NO or fill in the blanks as appropriate.
Circle the answer NO if the problem is infrequent.

B.

13. Do you sleep walk? YES NO

14. Do you talk in your sleep? YES NO

15. Have you been told you moan in your sleep? YES NO

16. Do you have dentures? If yes, circle: upper, lower, both YES NO

17. Do you grind your teeth while you sleep? YES NO

18. Do you often have frightening dreams or nightmares? YES NO

19. Have you had the same dream on different nights? YES NO

20. Do you frequently wake up screaming or are told that you do so? YES NO

Key for answers

1	2	3	4	5
Never (strongly disagree)	**Rarely (disagree)**	**Sometimes (not sure)**	**Usually (agree)**	**Always (agree strongly)**

21. I wake up often during the night. 1 2 3 4 5

22. When falling asleep or during sleep, I have "restless legs" (a feeling of crawling, aching, or inability to keep legs still) 1 2 3 4 5

23. At night my heart pounds, beats rapidly, or beats irregularly ("palpitation") 1 2 3 4 5

24. I feel that I have insomnia. 1 2 3 4 5

25. My desire or interest in sex is less than it used to be. 1 2 3 4 5

26. I smoke tobacco within two hours of bedtime. 1 2 3 4 5

27. How long is your longest wake period at night?
1. Less than 5 min. 2. Six to 19 min. 3. 20 min – 40 min
4. 40 min – 60 min 5. more than 60 min.

28. How many times in a night do you get up to urinate/ or wake up for other reasons?
1. None 2. One time 3. Two times
4. Three times 5. Four or more times

29. Are you bothered by leg cramps or pains in the calf during the night? 1 2 3 4 5

30. Have you ever been told that your legs twitch during the night? 1 2 3 4 5

31. How likely are you to doze off or fall asleep in the following situations, in contrast to appearing just tired?
Use the following scale to choose the most appropriate number for each situation:

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

	SITUATION: Patient to respond	**CHANCE OF DOZING: Spouse or bed partner to respond (about patient)**
Sitting and reading	_____	_____
Watching TV	_____	_____
Sitting, inactive in a public Place (theatre, meeting)	_____	_____
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	_____	_____

32. Do you sleep a lot or take many naps during the day? YES NO

33. Do you have to drink coffee or other caffeinated beverages in order to stay awake during the day? YES NO

_____

_____

How much? _____ Time of day: _____

34. Do you feel extremely tired or fatigued during the day even after you have slept all night? YES NO

35. Is your daytime performance in work or recreation less efficient than you would like it to be? YES NO

36. Do you feel distracted and unable to concentrate during the day? YES NO

37. Have you had a car accident or a near accident in the last year? YES NO

_____

_____

_____

C.

38. Do you watch the clock when awake at night? YES NO

39. Do you sleep better when away from your own bed? YES NO

40. Do you tend to awake during the night or in the morning with an unpleasant feeling of fear, anxiety, worry, depression, unhappiness, or confusion? YES NO

41. Do you take sedatives regularly? YES NO

42. If yes, is your sleep satisfactory when taking sedatives? YES NO

43. How long does it take you to "get going" in the morning after you have awakened? _____ minutes, _____ hours

44. Is there any other daytime symptoms or complaint which you feel may be related to sleeping difficulties? YES NO

_____

_____

_____

45. Have you ever been interviewed by a psychiatrist, psychologist, or a mental health professional? YES NO

46. Do you feel that you are living under unusual pressure or stress at the present time? YES NO

47. List things that make daytime or night time symptoms and complaints worse.

_____

_____

_____

48. Do you have a problem waking up in the morning? YES NO

49. What is your usual bedtime? _____ AM/PM Wake up time? _____ AM/PM

50. What is your preferable sleep position?
1. Back (Supine) 2. Side 3. Stomach (Prone)

51. How long does it usually take to fall asleep? _____ Minutes

52. Do you awaken because of:
- bed partner? YES NO - light? YES NO
- pet? YES NO - other noise? YES NO

53. Do you usually sleep with a bed partner? YES NO

54. Do you drink alcoholic beverages regularly? YES NO

55. Do you drink any beverages (alcohol, coffee, tea, cola) during the night? YES NO

56. Is your sleep disturbed when you do drink alcoholic beverages? YES NO

57. Do you consider that your sleep/wake schedule as unusually irregular? YES NO

58. Are your sleep/wake symptoms different during the weekend? YES NO

59. Do you have an occupation that involves shift work? YES NO

_____

_____

60. Do you find that your present sleep/wake schedule is inconvenient, inappropriate or unsatisfactory? YES NO

If yes, explain? _____

_____

(Example: Cannot get to sleep until late at night then have trouble getting up in time for work; fall asleep so early you cannot get anything done in the evening with your family, etc.) YES NO

61. Is there a particular schedule you would prefer and have difficulty achieving? YES NO

If yes, explain? _____

_____

(Examples: I would like to fall asleep earlier, sleep for six hours and then wake up earlier, I would like to stay up later, etc.)

62. List anything else not yet covered which especially interferes with your sleep.

_____

_____

63. Did you have a problem with sleep as a child? YES NO

_____

_____

D.

64. Would you like to be able to nap at particular times of the day? YES NO

65. Do you have times during the day when your memory completely fails you? YES NO

66. Have you ever "come to" and discovered that you had performed some complex activity without remembering it? YES NO

67. Do you sometimes have illusions that something is happening that really isn't? YES NO

Key for answers				
1 Never (strongly disagree)	2 Rarely (disagree)	3 Sometimes (not sure)	4 Usually (agree)	5 Always (strongly agree)

68. When falling asleep, I feel paralyzed (unable to move). 1 2 3 4 5

69. I feel unable to move (paralyzed) after a nap or in the morning. 1 2 3 4 5

70. I have dream-like images (hallucinations) when I awaken in the morning or after a nap even though I know I am not asleep. 1 2 3 4 5

71. I have slept for several days at a time, or at least I have been overwhelmingly sleepy for that long. 1 2 3 4 5

72. Now, I an very sleepy during the day and I struggle to stay awake. 1 2 3 4 5

73. I got bad grades in school because I was too sleepy. 1 2 3 4 5

74. I now have trouble doing my job because of sleepiness and fatigue. 1 2 3 4 5

75. I often have to let someone else drive the car because I am too sleepy to do it. 1 2 3 4 5

76. Sometimes I realize I have driven my car to the wrong place, and I cant remember how I did it. 1 2 3 4 5

77. I get "weak knees" when I laugh. 1 2 3 4 5

78. I get sudden muscular weakness (or even brief period of paralysis, being unable to move) when laughing, angry, or in situations of strong emotion. 1 2 3 4 5

79. How many work accidents have you had as a result of sleepiness or fatigue??

1. None
2. One
3. Two
4. Three
5. Four or more

INFORMATION FOR YOUR PHYSICIAN

ADM. NO. _____

Please answer the following questions and bring this record to your first examination. It will help your physician to know not only about your health but also about your family and relatives.

Date _____

Clinic No. _____ Your full name _____ Telephone Number _____

Age _____ Place of Birth _____ Race or Nationality of Parents _____

Religion _____ Education _____ Age on Completion _____ Occupation _____ How Long? _____
(Highest level attained)

Where and when have you lived or traveled outside the U.S. and Canada _____

	Living		Age or age at death	Present health or cause of death
Father	Yes	No	_____	_____
Mother	Yes	No	_____	_____
Spouse	Yes	No	_____	_____

Present Marriage – year _____ Previous Marriage – year and duration _____

Brothers No. Living _____ Health _____
No. Dead _____ Cause of death _____

Sisters No. Living _____ Health _____
No. Dead _____ Cause of death _____

Children Living _____ Ages and health _____

Children Dead _____ Ages and causes _____

Please circle illnesses which have occurred in any of your *blood relatives*

Diabetes	Cancer	Bleeding Tendency	Kidney Disease	Tuberculosis
Heart Disease	Stroke	High Blood Pressure	Nervous Illness	Allergy

Please circle illnesses or condition *you* have had

Diabetes	Glaucoma	Heart trouble	Syphilis	Vein trouble
Diabetes, insulin taking	Asthma	Jaundice	Gonorrhea	Bleeding tendencies
Cancer	Pneumonia	Kidney Disease	Rheumatic fever	Nervous disorder
Tuberculosis				

Please list other illnesses not requiring operation for which you were hospitalized _____

Have you had serious injuries, broken bones, etc? _____ List _____

Have you had allergies or sensitivity to medicines or other substances? _____ Please describe _____

Do you use tobacco now? _____ In the past? _____ Type and daily amount _____ How long? _____
Do you use alcoholic beverages? _____ Type? _____ Weekly amount _____ How long? _____
Please check the diseases against which you have been immunized

☐ Smallpox ☐ Tetanus ☐ Typhoid ☐ Polio ☐ Influenza ☐ Other _____

Previous operations Please list, giving dates, hospital where performed and name of surgeon _____

Previous x-ray therapy or similar treatment _____

Medications Please name or otherwise identify medicines now or recently used _____

Menstrual History Last period (Date onset) _____Periods are ☐ Regular ☐ Irregular Number of pregnancies____ Number of miscarriages ____
Have you taken Cortisone-type drugs? _____ Oral contraception? _____ Have you received a blood transfusion? _____ Date _____
Your weight dressed _____ How long have you been at this weight? _____

Please write the reason you came to the Pulmonary / Sleep Clinic at this time _____

What is your main medical problem now and how long have you had it? _____

What is your main symptom? (For example: pain in chest, shortness of breath) _____

Reviewed _____ Date _____
Physician