

# THE SLEEP DISORDERS CENTER OF CENTRAL TEXAS

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## CONFIDENTIAL PATIENT QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referral Source: \_\_\_\_\_

PLEASE DO NOT WRITE ON THIS SIDE OF THE PAGE

What is your primary concern/problem regarding your sleep?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you had this concern/problem? \_\_\_\_\_ # of months/years

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

If yes, who was the doctor and when were you seen?

\_\_\_\_\_  
\_\_\_\_\_

If yes, what was the diagnosis? \_\_\_\_\_

Did you have a sleep study?  Yes  No

If yes, when and where? \_\_\_\_\_

\_\_\_\_\_

What treatment, if any, was recommended? \_\_\_\_\_

\_\_\_\_\_

Was the treatment effective?  Yes  No

Do you have any allergies or reactions to drugs?  Yes  No

If yes, specify drug and reaction: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Previous PSG?

Y

N

## Medical History

Check the appropriate boxes if you have/have had any of the following conditions:

- |  |  |
|--|--|
| <input type="checkbox"/> Allergies                       | <input type="checkbox"/> Liver disease                                       |
| <input type="checkbox"/> Anemia/blood disease            | <input type="checkbox"/> Menopause   |
| <input type="checkbox"/> Arthritis/rheumatism            | <input type="checkbox"/> Mental illness                                      |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Seizures  |
| <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Sinusitis   |
| <input type="checkbox"/> Depression                      | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Diabetes (Type I/II)            | <input type="checkbox"/> Thyroid disease<br>(Hypothyroidism/Hyperthyroidism) |
| <input type="checkbox"/> Emphysema or Chronic Bronchitis | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Other Lung Disease              | _____  |
| <input type="checkbox"/> Ulcers/intestinal disease       | _____  |
| <input type="checkbox"/> Heartburn/acid reflux           | _____  |
| <input type="checkbox"/> Heart disease                   | _____  |
| <input type="checkbox"/> High blood pressure             | _____  |
| <input type="checkbox"/> High cholesterol/triglycerides  | _____  |
| <input type="checkbox"/> Kidney/bladder disease          | _____  |

Have you had your tonsils removed?  Yes ; At what age? \_\_\_\_\_  No

Have you had nose and/or throat surgery?  Yes; At what age? \_\_\_\_\_  No

Please list any other surgeries and/or hospitalization you have had:

Date	Reason
_____	_____
_____	_____
_____	_____

(If more spaces is needed, please continue on the back of this page)

## Family History

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

Medical    N    Y

	Father	Mother	Siblings	Children
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Narcolepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sleep        N    Y

**Social History**

Occupation and place of employment: \_\_\_\_\_  
\_\_\_\_\_

What is your work schedule? \_\_\_\_\_  
\_\_\_\_\_

Marital status:  Single       Domestic Partner       Married  
 Separated       Divorced       Widowed

Number of children and ages: \_\_\_\_\_

**EtOH**

Do you currently drink alcohol?  Yes  No

Do you have a drink just prior to going to bed?  Yes  No

Do you have a history of alcohol abuse/chemical dependency?  Yes  No

**Tobacco**

Do you currently use tobacco products?  Yes  No/never  No/stopped

If yes, Pipe \_\_\_\_\_# daily for \_\_\_\_\_months/years

Cigarettes \_\_\_\_\_# daily for \_\_\_\_\_months/years

Cigars \_\_\_\_\_# daily for \_\_\_\_\_months/years

Other \_\_\_\_\_#daily for \_\_\_\_\_months/years

If you had a history of tobacco usage but have quit using them, when did you quit and what products did you previously use? \_\_\_\_\_  
\_\_\_\_\_

**Caffeine**

Do you currently drink caffeinated beverages?  Yes  No

If yes, \_\_\_\_\_ # of cans of soft drinks daily

\_\_\_\_\_ # of cups of coffee daily

\_\_\_\_\_ # of cups/glasses of tea daily

\_\_\_\_\_ # of cups/glasses of cocoa/chocolate milk

**Weight Status**

Your current weight: \_\_\_\_\_ Height: \_\_\_\_\_

Are you on a diet?  Yes  No

What kind of diet? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you exercise?  Yes  No

If yes, what type(s) of exercise and how often? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your weight changed recently?  Yes  No

If yes, gain/loss of \_\_\_\_\_ lbs over \_\_\_\_\_ months/years

Approximately how much did you weigh at age 18 years? \_\_\_\_\_ lbs

Mood

Do you feel depressed?  Yes  No

If yes,  rarely  occasionally  frequently

Has your spouse/friends commented about you being irritable?  Yes  No

Do you (or others) feel you have had a recent personality change?

Yes  No If yes, specify: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Sleep Hygiene

On weekdays/workdays, what time do you:

Go to bed? \_\_\_\_\_ a.m./p.m. Get up? \_\_\_\_\_ a.m./p.m.

On weekend/days off, what time do you:

Go to bed? \_\_\_\_\_ a.m./p.m. Get up? \_\_\_\_\_ a.m./p.m.

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/hours

Are any of your naps involuntary?  Yes  No

If yes, when do they occur?: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you eat, argue, worry, write, and/or read in bed?  Yes  No

If yes, specify: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do any of your children and/or pets sleep in the bedroom with you?

Yes  No If yes, please specify: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What would be an ideal sleep schedule for you?

Go to bed at \_\_\_\_\_ a.m./p.m. Get up at \_\_\_\_\_ a.m./p.m.

## Insomnia

Do you have difficulty falling asleep?  Yes  No

If yes, how long does it take? \_\_\_\_\_ # minutes/hours \_\_\_\_\_ # of nights weekly

Do you have several awakenings during the night?  Yes  No

If yes, \_\_\_\_\_ # of times nightly \_\_\_\_\_ # of nights weekly

Why do you awaken? \_\_\_\_\_  
\_\_\_\_\_

Do you have extended periods of wakefulness during the night?

Yes  No If yes, \_\_\_\_\_ # minutes/hours \_\_\_\_\_ # of nights weekly

Do you awaken too early in the morning and stay awake?  Yes  No

If yes, at what time \_\_\_\_\_ a.m. \_\_\_\_\_ # of times weekly

## Parasomnias

*Some of the following questions will ask you to rate the frequency of certain symptoms. If you check yes to any of the boxes, please use the scale below as a guide when answering the questions.*

Frequently = 1 or more times per week  
Occasionally = 1 or more times per month  
Rarely = the issue occurs but it is less than the above

Did you have any sleep problems as a child?  Yes  No

If yes, specify: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you currently:

Have intense nightmares or night terrors?  Yes  No  
If yes,  rarely  occasionally  frequently

Grind or clench your teeth at night?  Yes  No  
If yes,  rarely  occasionally  frequently

Talk in your sleep?  Yes  No  
If yes,  rarely  occasionally  frequently

Walk in your sleep?  Yes  No  
If yes,  with or  without eating;  
 rarely  occasionally  frequently

Have incontinence of urine during sleep?  Yes  No  
If yes,  rarely  occasionally  frequently

## Hypersomnia

Are you sometimes drowsy while driving?  Yes  No

If yes,  usually  occasionally  
 only on long highway trips

Have you ever had an accident or near miss because of dozing while driving?

Yes  No If yes, when and describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

For the following situations, indicate the chance of dozing or falling asleep (not feeling tired) by using the scale below:

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

<u>SITUATION</u>	<u>CHANCE OF DOSING</u>
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g., a meeting or a theatre)	_____
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 while stopped for a few minutes in traffic	_____
Total	= _____

Sleep Prl

Have you ever been unable to move or paralyzed as you were falling asleep or waking up?  Yes  No If yes, describe: \_\_\_\_\_

\_\_\_\_\_

Cpxy

Have your ever felt sudden muscle weakness when you laughed, were surprised, or were angry?  Yes  No If yes, describe: \_\_\_\_\_

\_\_\_\_\_

Hh

Have you ever had exceptionally vivid dreams *as you were falling asleep or waking up*?  Yes  No If yes, describe: \_\_\_\_\_

\_\_\_\_\_

RO - Nar/MSLT

\_\_\_\_\_

PLMS

Has your bed partner ever complained that you move excessively in your sleep?  Yes  No If yes,  rarely  occasionally  frequently

Do you awaken yourself by kicking your legs?

Yes  No If yes,  rarely  occasionally  frequently

RLS

Has your bed partner ever complained of leg kicks?

Yes  No If yes,  rarely  occasionally  frequently

OSAS

Do you have a restless sense of discomfort in your legs while resting or before falling asleep?  Yes  No If yes,  rarely  occasionally  frequently  
If yes, describe: \_\_\_\_\_

Do you snore?  Yes  No  Unknown

If yes, is it  occasionally or  continuously;  
and is it  only on your back or  in any position.

Indicate the severity of your snoring by using the scale below:

- Grade 1: Heard only if you listen close to the face
- Grade 2: Heard in the room
- Grade 3: Heard just outside the bedroom with the door open
- Grade 4: Heard outside the bedroom with the door closed

Have you been told you stop breathing during sleep?

Yes  No If yes,  rarely  occasionally  frequently

Do you ever awaken gasping for air?

Yes  No If yes,  rarely  occasionally  frequently

Do you awaken with a dry mouth?

Yes  No If yes,  rarely  occasionally  frequently

Do you awaken with nasal congestion?

Yes  No If yes,  rarely  occasionally  frequently

Do you awaken with morning headaches?

Yes  No If yes,  rarely  occasionally  frequently

Do you awaken with a sore throat?

Yes  No If yes,  rarely  occasionally  frequently

Do you have night sweats?

Yes  No If yes,  rarely  occasionally  frequently

Do you have heartburn at night?

Yes  No If yes,  rarely  occasionally  frequently

Do you feel unrefreshed after sleeping?

Yes  No If yes,  rarely  occasionally  frequently

Do you have problems with memory or concentration?

Yes  No If yes,  rarely  occasionally  frequently

Are you ever confused in the morning?

Yes  No If yes,  rarely  occasionally  frequently

On the average, how many times per night do you awaken to urinate? \_\_\_\_\_

Please tell us if there are any other concerns that you have about your sleep that were not covered in the above questionnaire:

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Thank you for taking the time to fill out this questionnaire. We look forward to seeing you at your scheduled consultation.

*The Staff of the Sleep Disorders Center  
of Central Texas*