Baystate Regional Sleep Program

BAYSTATE MEDICAL CENTER

Neurodiagnostic and Sleep Center Phone: 413-794-5600 Fax 413-787-5713 Baystatehealth.com/sleep

New Patient Sleep Questionnaire

(If you have already done a questionnaire as part of a sleep clinic or sleep study evaluation please let the staff know. You do not have to fill out another questionnaire. Please let them know if there have been any interval changes in medications or medical history)

Patient Name: ____________________________ **Date:** ______________________________

Referring MD: ____________________________ **PCP:** ______________________________

Insurance: ________________________________ **Date of Birth:** ______________________

Pharmacy: ________________________________ **Best Phone number:** __________________

Age:____ **Sex: Male / Female Height:** __ **(inches) Weight:** ___ **(lbs.) Neck size:** __ **(inches)**

What is the reason you are being referred? ____

____

Epworth Sleepiness Score: How likely are you to doze in the following situations?
0= Never 1= Slight Chance 2= Moderate Chance 3= High Chance

______ Sitting & reading
______ Watching television
______ Sitting inactive in a public place (i.e. theater)
______ Passenger in a car for an hour without a break
______ Lying down to rest in the afternoon
______ Sitting and talking to someone
______ Sitting quietly after lunch without alcohol
______ In a car while stopped for a few minutes in traffic
______ Total Score

Sleep Schedule:	Weekdays (school/work days)	Weekends
What time do you usually go to bed?	__________	__________
What time do you usually wake up?	__________	__________
Do you usually take a nap? For how long?	__________	__________

1. How many **hours do you usually sleep** at night? ____________ Hours

NOTE: 0 = Never 1 = Rarely 2 = Sometimes 3 = Frequently N/A =not applicable

2. Do you have **difficulty falling asleep**? 0 1 2 3 N/A

3. How long does it take you to **fall asleep**? _____ min _____ hours

4. How **many times do you wake** at night? ______________________________

5. Is **waking up frequently** at night a problem? 0 1 2 3 N/A

6. Do you **awaken early** and have trouble getting back to sleep? 0 1 2 3 N/A

NOTE: 0 = Never 1 = Rarely 2 = Sometimes 3 = Frequently N/A =not applicable

Question					
1. Do you **snore** at night? Is it worse sleeping on your back? ☐ Yes ☐ No ☐ Don't know Check here if you don't know whether or not you snore ☐	0	1	2	3	N/A
2. Is your snoring **loud**?	0	1	2	3	N/A
3. Does your **snoring bother** other people?	0	1	2	3	N/A
4. Have you ever been told that you **stop breathing during sleep**?	0	1	2	3	N/A
5. Do you ever wake up from sleep **gasping for air**?	0	1	2	3	N/A
6. Do you get the **irresistible urge to sleep** despite wanting very much to stay awake?	0	1	2	3	N/A
7. Have you had any accidents or near-**accidents while driving** due to sleepiness?	0	1	2	3	N/A
8. Do you have **daytime fatigue** or **decreased energy**?	0	1	2	3	N/A
9. Are you still **tired/unrefreshed** when you awaken in the morning?	0	1	2	3	N/A
10. Do you have **headaches** upon awakening in the morning?	0	1	2	3	N/A
11. Do you **urinate frequently** at night?	0	1	2	3	N/A
12. Do you have **heartburn** or chest pain ("hot burps") during sleep?	0	1	2	3	N/A
13. Do you have **nasal congestion**?	0	1	2	3	N/A
14. Do you **breathe through your mouth** when you sleep?	0	1	2	3	N/A
15. Do you ever wake up with a **dry mouth**?	0	1	2	3	N/A
16. Do you **sleep on your back**?	0	1	2	3	N/A
17. Do you have **nightmares**?	0	1	2	3	N/A
18. Do you have **leg jerks** during sleep?	0	1	2	3	N/A
19. Do you have an **urge to move your legs** due to abnormal feelings of restlessness, discomfort or sensations?	0	1	2	3	N/A
20. Is the urge to move your legs **worse with rest**?	0	1	2	3	N/A
21. Does the urge to move your legs temporarily **improve with activity**?	0	1	2	3	N/A
22. Does the urge to move your legs increase in the evening or night?	0	1	2	3	N/A

NOTE: 0 = Never 1 = Rarely 2 = Sometimes 3 = Frequently N/A =not applicable

23. Have you ever had **sudden weakness when excited**, surprised or laughing? (ie. Knee buckling, jaw dropping, falling to the ground) 0 1 2 3 N/A

24. Have you ever **felt paralyzed** (momentary inability to move) when waking up or falling asleep? 0 1 2 3 N/A

25. Have you ever had **vivid lifelike images** or hallucinations as you fall asleep or wake up? 0 1 2 3 N/A

26. Do you **dream during short naps**? 0 1 2 3 N/A

27. Do you **grind your teeth** at night? 0 1 2 3 N/A

28. Do you **eat in your sleep** without realizing it? 0 1 2 3 N/A
(ie. find empty food cartons, crumbs on awakening)

29. Do you **act out your dreams** in your sleep? 0 1 2 3 N/A
(ie. Yell, punch, kick or other movements in the setting of dreams)

30. Do you have a history of **sleepwalking**? ____ No ___ Yes

30. Has your **weight changed** recently? ☐ Yes ☐ No How much? ______________________
Weight gain ☐ Weight loss ☐

Sleep Studies and CPAP Use (if applicable):

Have you ever had a sleep study? Where? When?
____

Have you ever been diagnosed with sleep apnea or another sleep disorder? What?
____

Are you currently using CPAP/BiPAP? ☐ Yes ☐ No What pressure? _________________________

How often do you currently use CPAP? ___________ days/week ___________ hours/night

If you are not using it now, did you use CPAP/BIPAP in the past? ☐ Yes ☐ No When? _________

Did you have trouble tolerating CPAP/BIPAP? ☐ Yes ☐ No Why? __________________________

If you are not using PAP now, for how long did you try/use PAP?
______ days/months/years (circle) __________ hours/ night

What type of mask did you/ do you use? Full face Nasal Pillows Nasal Other _______________

Who is your home care company? ____
Baystate Home Infusions North Atlantic Medical Apria Flynn’s Lincare J&L

Medical History:
Do you have any of the following?

- ☐ Coronary artery disease
- ☐ Myocardial infarction (heart attack)
- ☐ Congestive heart failure, EF if known_______
- ☐ Atrial fibrillation
- ☐ Stroke/ TIA
- ☐ Hypothyroidism
- ☐ Diabetes Mellitus
- ☐ High blood pressure
- ☐ Obesity
- ☐ High cholesterol
- ☐ Asthma
- ☐ COPD (emphysema/chronic bronchitis)
- ☐ Pulmonary Hypertension
- ☐ Gastric reflux (heartburn)
- ☐ Seasonal allergies
- ☐ Depression
- ☐ Bipolar
- ☐ Seasonal affective disorder
- ☐ Anxiety
- ☐ Fibromyalgia
- ☐ Chronic fatigue syndrome
- ☐ ADHD
- ☐ Migraines
- ☐ Seizures/ Epilepsy
- ☐ Neuromuscular disorder
- ☐ Parkinson’s Disease
- ☐ Restless legs syndrome
- ☐ Broken nose/ face
- ☐ Dental problems
- ☐ Sinus problems
- ☐ Deviated nasal septum
- ☐ Surgery on the nose
- ☐ Tonsillectomy
- ☐ Adenoids removed
- ☐ Kidney disease
- ☐ Anemia

Other: ______________
____

Social History:
Do you share a bed with? (circle all that apply) Significant other Children Pets

Occupation: ____

What is your work/ school schedule?____

Tobacco: Do you smoke or chew tobacco? ☐ Yes ☐ Never ☐ Quit
______# packs per day _______ #years If quit when _____________________

Alcohol: Assuming one glass of wine, one shot of liquor or one beer is one drink, how many alcoholic beverages do you typically drink **each day** on weekdays? ______
on weekends? _________
Does alcohol alter or interfere with your sleep? ☐ Yes ☐ No

Caffeine: How many caffeinated beverages (coffee, tea, soda) do you consume daily?
______ 8 oz servings. What do you consume (ie. 8 oz coffee, 1 can soda)? __________________

Drugs: Do you currently use recreational drugs (ie. Marijuana, cocaine)? ☐ Yes ☐ No
If yes, describe ____

Exercise: How many times a week do you exercise? ___________________________________

What time of day do you usually exercise? ____

Family History: Does anyone in your family have a sleep disorder? Who?

Sleep apnea	☐ Yes ☐ No	____
Snoring	☐ Yes ☐ No	____
Insomnia	☐ Yes ☐ No	____
Narcolepsy	☐ Yes ☐ No	____
Night terrors	☐ Yes ☐ No	____
Restless leg syndrome	☐ Yes ☐ No	____
Sleep walking	☐ Yes ☐ No	____

List any medications you take on a daily basis including tranquilizers, stimulants, sleeping pills and herbal medications: *If you brought a list with you, we can copy it.* (Please continue on other side if needed)

MEDICATION	**DOSE/ HOW MANY TIMES A DAY**	**PURPOSE OF MEDICATIONS**

Please list your drug allergies: ____

Have you ever taken stimulants (Provigil, Nuvigil, Ritalin, Amphetamines)? ☐ Yes ☐ No
If yes, what and when? ____

What sleep medications including herbal and over the counter have you tried in the past?
____

Review of Systems:
Please indicate if you have had these symptoms in the last month

General
☐ Good general health
☐ Night sweats
☐ Fevers
☐ Fatigue

Eyes
☐ Eye disease or injury
☐ Blurry vision
☐ Double vision
☐ Eye pain

Ear, Nose, Throat
☐ Loss of hearing
☐ Ringing in the ears
☐ Nasal Obstruction
☐ Sore gums or tongue
☐ Dental problems
☐ Jaw pain
☐ Hoarseness
☐ Neck stiffness or pain
☐ Mouth sores
☐ Nose bleeds
☐ Swollen glands in the neck

Cardiovascular
☐ Chest pain
☐ Palpitations
☐ Irregular heart beat
☐ Swollen feet or legs
☐ Lower leg pain when walking
☐ Shortness of breath lying flat

Respiratory
☐ Shortness of breath
☐ Wheezing
☐ Chronic or frequent cough
☐ Spitting up blood

Gastrointestinal
☐ Loss of appetite
☐ Difficulty swallowing
☐ Heartburn
☐ Abdominal pain
☐ Nausea
☐ Vomiting
☐ Change in bowel movements
☐ Constipation
☐ Diarrhea
☐ Rectal bleeding

Muscle/ Skeletal
☐ Back pain
☐ Neck pain
☐ Joint pain
☐ Joint swelling
☐ Muscle cramps

Endocrine
☐ Excessive thirst
☐ Intolerance to heat
☐ Intolerance to cold
☐ Hot flashes
☐ Glandular or hormone problem
☐ Dry skin
☐ Change in hat or glove size

Hematologic
☐ Lymph node pain or swelling
☐ Easy bleeding or bruising
☐ Anemia
☐ Leg clots
☐ Past transfusion

Genitourinary
☐ Unable to hold urine
☐ Pain or burning on urination
☐ Excessive urination
☐ Blood in urine
☐ Pain or lump in testis
☐ Sexual difficulty
☐ Pain with intercourse
☐ Irregular periods
☐ Pain or lump in breasts
☐ Kidney stones

Skin
☐ Rash
☐ Dry skin
☐ Hives or itching
☐ Change in hair or nails
☐ New or changed dark spot
☐ Change in skin color

Nervous / Mental
☐ Headaches
☐ Dizziness
☐ Loss of balance
☐ Fainting
☐ Light headed
☐ Memory loss
☐ Numbness
☐ Muscle weakness
☐ Tremors
☐ Paralysis
☐ Head injury
☐ Depression
☐ Anxiety
☐ Stress
☐ Confusion

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