Neurology Specialists Sleep Questionnaire

Date of Birth: **Age:**

Contact phone numbers, Day: **Evening:** **Cell:**

Referring Physician: **Family physician, if different:**

Medications, Vitamins and Supplements (do not attach list, please write out) :

Past Sleep Studies:

Past Surgeries: (include any tonsil, nasal or throat surgery)

Drug allergies or intolerance:

Past medical history:

High Blood Pressure	Thyroid Problems	Prostate Disorder
Cancer	Bronchitis	Fibromyalgia
Heart Problems	Asthma	Depression
Reflux	Emphysema	Broken Nose
Diabetes	Panic Attacks	High Cholesterol
Obesity	PTSD	Supplemental Oxygen

Family History:

High Blood Pressure	Sleep Apnea	Heart Disease	
Diabetes	Stroke	Restless legs	Other:

Social History:

Currently Married?	Occupation:	Disabled?
Have you ever used tobacco? Y/N	Have you quit? Y/N	If so, when?
Do you drink alcohol most days?		

System Review: ***circle those symptoms that have been of concern to you:***

Headache, numbness, tingling, seizures, memory problems, walking difficulty,

Sudden blurring of vision, unable to open eyes, seeing two of everything

Hearing loss, ringing in the ear, slurred speech, can't swallow, chronic sinus problems, tonsils removed

Fainting, palpitations, chest pain, swelling in the legs

Persistent cough, shortness of breath, wheezing, seasonal allergies

Soiling or wetting undergarments, urinary infections, abdominal pain, frequent urination

Back or neck pain, joint pain, muscle pain, muscle cramps

Hallucinations, depression, anxiety, stress, panic attacks, claustrophobia, history of abuse

night sweats, unusual weight change, anemia

Excessive thirst, unusual intolerance to cold, "hot flashes"

Name (print) _____ Date _____

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Please be as complete as possible and estimate if necessary.

1. Why have you been referred for a sleep evaluation?
2. When did you first have ***any*** symptoms of the problem?
3. Was there anything that triggered it?
4. Are your symptoms: Worsening / improving/ Stable?
5. What is your best sleep position?
6. Estimate how much sleep you get per 24 hour day:
7. When do you fall asleep on workdays?
8. When do you fall asleep on non-work days?
9. When do you finally awaken on workdays?
10. When do you finally awaken on non-work days
11. How long does it take you to fall asleep after "lights out"?
12. How often do you wake to urinate after falling asleep?
13. How do you feel upon awakening?
14. How often do you exercise?
15. Do you have a television in the bedroom?

Place yourself in the following situation; would you doze or nod off?

Situation	**Chance of dozing** (0 = never, 1 = slight, 2 = moderate, 3 = high)
Sitting and reading	_____
Watching TV	_____
Sitting, in a public place (such as church)	_____
As a passenger in a car for an hour	_____
If you were to lay down in the afternoon for 30 minutes	_____
Sitting and talking to someone	_____
Sitting quietly in an easy chair for 30 minutes after lunch	_____
In a car, while stopped for a few minutes in traffic	_____
	Total _____

Name (print) _____ Date_____

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YES	NO	
		Have you nodded off while driving?
		Have you been involved in an accident or near-accident because of sleepiness?
		Do you ever dream while awake, i.e. hallucinate?
		Have your muscles gone limp when excited, laughing, angry or surprised?
		Did you ever awaken to find you could only move your eyes?
		Do you frequently awaken with a headache?
		Have you been told that you snore?
		Are you a mouth breather at night?
		Do you suddenly awake with a catch of your breath or "snort"?
		Have you been told that you pause or hold your breath during sleep?
		Do your hands "fall asleep" at night?
		Do you toss and turn?
		Do you have a vague sense of restlessness in the legs?
		Do you have heartburn?
		Do you wet the bed?
		Do you talk in your sleep?
		Do you walk in your sleep?
		Do you have frequent nightmares?
		Do you clench your jaw or grind your teeth?
		Do you move your arms and/or legs violently in response to (i.e. acting out) dreams?
		Have you gained more than 10 pounds in the past 10 years?
		Do you nap most days?
		Are you a "clock-watcher" at night?
		Do you have caffeinated tea, coffee or soda daily?
		Have you worked night or third shift often?

Please, do not write below this line. Thank you.

Examination

Blood Pressure: Pulse: Resp: O2 Sat:	Height: Weight: BMI: Neck Circumference:

Appearance:	Neck:	Carotids:
Cranial Nerves:	Nose:	Heart:
Motor:	Oropharynx:	JVD:
Sensation:	Tonsils:	Lungs:
Coordination:	Tongue:	Extremities:
Reflexes:	Uvula:	Peripheral Pulses:
Mentation:	Dentition:	

Physician's Signature _____

Name (print) _____ Date _____