CLEAR LAKE SLEEP CENTER
Patient Questionnaire

Date: _____

Name: _____ Date of Birth: _____

Sex: _____ Height: _____ Weight: _____ PCP: _____

Specialist: _____ Referring Physician: _____

1. What is your primary sleep problem? _____
_____

2. Who initially suspected a sleep problem? _____

3. Do you currently have a bed partner/roommate? _____
If yes, please have them assist you with this questionnaire.

4. Have you been seen by a sleep specialist before? _____

5. Have you had difficulty at work/school due to your sleep problem? _____

6. Have you had difficulty driving due to your sleep problems? _____

7. What is your primary work shift? _____

8. How many caffeinated drinks do you have daily? _____

9. If you snore, please rate the noise level:

4 ○	3 ○	2 ◉	1 ○
heard outside room	wakes bed partner	easily heard	barely noticeable

10. Do you take naps during the day? ○ Yes ○ No

11. Have you ever smoked cigarettes? ○ Yes ○ No
How many packs per day? _____
How many years did you smoke? _____
Have you quit smoking yet? ○ Yes ○ No

12. Has anyone ever observed you stop breathing when you sleep? ○ Yes ○ No

13. Do you awaken gasping or choking? ○ Yes ○ No

14. Do you have trouble falling asleep? ○ Yes ○ No

15. Do you kick or twitch your legs when you sleep? ○ Yes ○ No

16. How many times do you awaken during the night? _____

17. How many times do you get up to urinate at night? _____

18. Do you have creepy/crawly feelings, numbness of legs, when you are trying to fall Asleep? ○ Yes ○ No

19. Have you ever used diet pills? ○ Yes ○ No

20. Have you ever used stimulant drugs before? ○ Yes ○ No
    Have you ever used marijuana? ○ Yes ○ No
    Have you ever used cocaine or other drugs? ○ Yes ○ No
    Are you currently using any of the above? ○ Yes ○ No
    If yes which ones? _____

21. Do you sit up and scream while asleep or suddenly wake up scared? ○ Yes ○ No

22. Do you walk while asleep, with no recall the next day? ○ Yes ○ No

23. Do you have frightening nightmare or dreams? ○ Yes ○ No

24. Have you felt paralyzed, unable to move, but mentally alert while falling asleep or awakening? ○ Yes ○ No

25. Have you had a sudden physical weakness of arms, legs, or face when laughing? crying or during other emotional situations? ○ Yes ○ No

26. Do you have palpitations or chest pain at night? ○ Yes ○ No

27. How much alcohol do you consume within three hours of bedtime? _____
    How much alcohol do you consume within a 24-hour period? _____

28. Please explain strange feelings or behavior you have or had during the night.

    _____

    _____

29. Please list any medication you are currently taking:
    (Include sleeping pill or Melatonin)

_____ _____ _____

_____ _____ _____

30. Have you now or in the past experienced any health problems in the following areas?

High blood pressure		Shortness of breath	
Deviated nasal septum		Chronic cough	
Sinus problems		Asthma	
Tonsillectomy		Emphysema	
Heart Disease		Thyroid Disease	
Psychiatric		Diabetes	
Heartburn		Reflux	

Please list any other medical problems you have or have had:

31. Sleepiness scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

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

1. Sitting and reading
2. Watching T.V.
3. Sitting inactive in a public gathering
4. As a passenger in a car for an hour without break
5. Lying down in the afternoon circumstances permitting
6. Sitting and talking to someone
7. Sitting quietly after lunch not having consumed alcohol
8. Driving a car that has stopped briefly at a red light

TOTAL