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NEW PATIENT QUESTIONNAIRE

Name: ________________________________ Date of Birth: _______________

Height: _________ Weight: _________ Neck Size: (inches) _________

Occupation: _______________ Do you have a CDL/Pilots License? ❑Yes ❑No

Reason for this appointment: (check all that apply)

❑Snoring ❑ Sleep apnea ❑Insomnia ❑ Restless legs ❑ Narcolepsy ❑Shift work

Other____

Do you have any symptoms of sleep apnea? (check all that apply) ❑ N/A

❑Snoring ❑Witnessed apneas ❑Choking/ gasping episodes ❑Fatigue

❑Daytime sleepiness ❑Non refreshing sleep ❑ Frequent awakenings at night

❑ Frequent urination at night ❑Memory issues ❑Mood problems ❑ Difficulty with attention/concentration ❑Morning headache ❑Dry mouth/sore throat ❑Motor vehicle accidents from falling asleep while driving

Have you ever had a sleep study? ❑Yes ❑No

Location: ____________________________ Date: ______________

Do you currently use any of the following? (mark all that apply) ❑ N/A

❑ CPAP ❑ BiPAP ❑ Oxygen ❑ Oral Appliance

Do you have any issues using CPAP? (mark all that apply) ❑ N/A

❑ Mask issues/leaks ❑ Too much CPAP pressure ❑ Nasal congestion ❑ Dry mouth

Which DME (durable medical supply) company do you use? ❑ N/A

❑ Norco ❑ Apria ❑ Lincare ❑ Sleep Technologies ❑ Other:

Do you have any of the following sleep problems? (mark all that apply)

❑ Trouble falling asleep ❑ Trouble staying asleep

❑ Restless legs - Unpleasant or uncomfortable feeling in your legs that causes an urge to move them. ❑Yes ❑No Is the urge worse when you are not moving? ❑Yes ❑No Does the urge go away after you move your legs? ❑Yes ❑No Does the urge happen mostly in the evening/night?

❑ Sleep walking ❑ Sleep eating ❑ Acting out dreams ❑ Teeth grinding ❑ Nocturnal cramps

❏ Daily periods of irrepressible need to sleep or daytime lapses into sleep

❏ Sleep paralysis ❏ Hallucinations when going to/waking up from sleep

What is your typical sleep schedule?

Bed time: _____________ Amount of time it takes to get to sleep: ________________

Wake up time: ______________Do you take naps? ❏Yes ❏No; How often? ❏Daily ❏few times/week

Is your bedroom comfortable for sleeping? ❏Yes ❏No

Currently on sleep medication? ❏Yes, _______________ ❏No

EPWORTH SLEEPINESS SCALE

Grade your tendency to fall asleep during the following situations based on how you feel right now.

0 = Never 1 = Slight chance 2 = Moderate chance 3 = High chance

ACTIVITY	0	1	2	3
Sitting and reading	❏	❏	❏	❏
Watching TV	❏	❏	❏	❏
Sitting inactive in a public place	❏	❏	❏	❏
As a passenger in a car for 30 minutes without a break	❏	❏	❏	❏
Lying down to rest in the afternoon	❏	❏	❏	❏
Sitting and talking to someone	❏	❏	❏	❏
Sitting quietly after lunch	❏	❏	❏	❏
In a car while stopping for a few minutes	❏	❏	❏	❏

TOTAL: ________

Do you have the following medical conditions? (mark all that apply)

❏ Heart attack ❏ Acid Reflux ❏ Chronic sinusitis

❏ Congestive heart failure ❏ Asthma ❏ Parkinson's

❏ High blood pressure ❏ COPD ❏ Dementia

❏ Stroke/TIA ❏ Chronic pain ❏ Seizures/epilepsy

❏ Atrial fibrillation ❏ Fibromyalgia ❏ Depression

❑ Heart block
❑ Diabetes
❑ Anxiety
❑ PTSD
❑ Thyroid issues
❑ Cancer
❑ Liver disease
❑ Kidney failure
❑ Other

Surgical History
❑Hysterectomy ❑Thyroidectomy ❑Sinus surgery ❑Tonsillectomy
❑ Adenoidectomy ❑UPPP
❑ Other
____

CURRENT MEDICATION LIST (use additional sheet if needed)
MEDICATION/SUPPLEMENT DOSE FREQUENCY

Allergies

Medications ____

Do you use any of the following? (mark all that apply)
❑ Tobacco amount_______________ ❑ Alcohol amount_______________ ❑ Caffeine amount_______________
❑ Marijuana _____________ ❑ Other drugs _______________