

**INTAKE FORM AND SLEEP QUESTIONNAIRE**

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

Address: \_\_\_\_\_

Primary Phone: (\_\_\_\_) \_\_\_\_\_ Secondary Phone: (\_\_\_\_) \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Do you have insurance through the Affordable Care Act (commonly called Obama Care)?  Yes  No

How did you find out about us?  My doctor  My friend  My family  My insurance  Your website  Advertisement

Referring Provider: _____ Address: _____ Phone: _____	Primary Care Provider (PCP): _____ Address: _____ Phone: _____
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What is your height? \_\_\_\_\_ Feet \_\_\_\_\_ Inches Gender:  Male  Female

What is your weight today? \_\_\_\_\_ Weight one year ago? \_\_\_\_\_ Weight five years ago? \_\_\_\_\_

**My Main Sleep Complaint (please explain):** \_\_\_\_\_

**Reason your doctor sent you to our office (please explain):** \_\_\_\_\_

**In the past 12 months have you had:** **Physical Exam by PCP** YES NO **Complete Blood Count** YES NO **Thyroid Test** YES NO

*Please check all of the following statements that are true about your sleep:*

**Breathing Problems:**

- I have been told that I snore
- I have been awakened by my own snoring
- I have been told I stop breathing during sleep
- I sweat a great deal at night

**Duration of Symptoms:** \_\_\_\_\_ months / years

- I wake up at night choking, smothering or gasping for air
- My snoring / breathing is worse if I fall asleep after alcohol
- My snoring / breathing is worse if I sleep on my back
- My heart pounds / beats rapidly or beats irregularly at night

**Daytime Sleepiness:**

- I take daytime naps
- I fall asleep while watching TV
- I fall asleep in sedentary situations
- I performed poorly at work due to sleepiness
- I performed poorly at school due to sleepiness
- I have had "blackouts" or periods when I am unable to remember what just happened
- I have slept for several days at a time, or at least I have been overwhelmingly sleepy for that long
- I see dream-like images (hallucinations) either just before, just after a daytime nap or as I wake up in the morning, even though I am not asleep
- I have had the inability to move (paralyzed) while falling asleep or when waking up
- I get sudden muscular weakness when laughing, angry or in situations of strong emotions
- I need "something" to help me stay awake during the day, I use \_\_\_\_\_

**Duration of Symptoms:** \_\_\_\_\_ months / years

- I am sleepy during the day, struggling to stay awake
- I have fallen asleep while driving
- I have fallen asleep during conversations
- I have had auto accidents due to falling asleep while driving
- I have had injuries as the result of sleepiness

**Past Sleep Evaluation and/or Treatment:**

- I have had a previous sleep disorder evaluation
- I have been prescribed PAP for home use
- I wear oxygen at night
- Please list 1) Date of Prior Sleep Study 2) Diagnosis 3) Treatment 4) Sleep Lab Name: \_\_\_\_\_

**Duration of Symptoms:** \_\_\_\_\_ months / years

- I have had a previous overnight sleep study
- I have had surgical treatment for a sleep disorder
- I have a family member with sleep apnea

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

**Restlessness Problems:**

- I am a restless sleeper
- I wake up often during the night
- I have talked in my sleep as an adult
- I have walked in my sleep as an adult
- I grind my teeth in my sleep

**Duration of Symptoms:** \_\_\_\_\_ months / years

- I have a difficult time falling back to sleep after I awaken
- I typically wake up from sleep to go to the restroom
- I have been told that I kick/jerk my legs/arms during sleep
- I sometimes act out my dreams
- I have injured myself or another while acting out a dream

- I have a strong urge to move my legs (restless leg symptoms) which I notice in the evenings, especially when I'm sitting in the evening or lying down to in bed** (example: activities that bother me at night do not bother me during the day.)
- I have an unusual feeling my legs and I'm unable to resist moving them** (the need to move is often accompanied by hard-to-describe sensations. Some words used to describe these include: "creeping, itching, pulling, creepy-crawly, tugging or gnawing.")
- These symptoms start or become worse when I am resting** (example: the longer I rest, the greater the chance the symptoms will occur and the more severe they are likely to be; it can occur as a passenger in a car, on an airplane, in a movie theatre, etc.)
- These symptoms get better when I move** (example: the relief is complete or partial but generally starts very soon after starting an activity. Relief persists as long as the motor activity continues.)

**Other Sleep Problems:**

- I have trouble falling asleep / insomnia
- My sleep is disturbed by sadness or depression
- I have a decreased desire / interest in sex
- I have a lot of nightmares (frightening dreams)
- I have racing thoughts when I try to fall asleep
- I have difficulty returning to sleep if I wake up during the night
- I wake up early in the morning, despite being tired, I am unable to return to sleep
- I need 'something' to help me get to sleep and/or stay asleep. I use \_\_\_\_\_

**Duration of Symptoms:** \_\_\_\_\_ months / years

- I have been unable to sleep at all for several days
- I have considered or attempted suicide
- I am unhappy about loving relationships in my life
- A family member has been hospitalized for a psychiatric illness
- I use alcohol to cope with stress

**Sleep Habits:**

- I usually watch TV in bed prior to sleep
- I usually read in bed prior to sleep
- I eat a snack at bedtime
- I work a rotating shift or I am a shift worker
- I smoke prior to bedtime or when I awaken during the night
- I eat if I wake up during the night
- I often travel across two (2) or more time zones
- I drink alcohol in the evening time to help get to / stay asleep

**Bedroom Habits:**

- I sleep alone
- I share a bed with someone
- I share a dwelling but have separate bedrooms
- I share the bed with pets
- I have an uncomfortable bed or pillow
- I have an uncomfortable temperature in the bedroom
- I have a noisy bedroom or have too much light in the bedroom
- I have too many electrical devices in the bedroom

**Sleep Pattern:**

Typical bedtime \_\_\_\_\_ AM/PM  
How many awakenings in the night? \_\_\_\_\_  
Typical wake-up time \_\_\_\_\_ AM/PM

How many minutes to fall asleep \_\_\_\_\_  
Do you fall back to sleep easily? YES / NO  
Do you nap? YES / NO If yes, when / how long \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

### Epworth Sleepiness Scale

**NOTE: Your answers below should be based on the worst you've felt in recent memory . . .**

*Use the following scale to choose the most appropriate number for each situation:*

- |   |   |
|---|---|
| 0 = would never doze or sleep.          | 2 = moderate chance of dozing or sleeping |
| 1 = slight chance of dozing or sleeping | 3 = high chance of dozing or sleeping     |

Situation	Chance of Dozing or Sleeping
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Stopped for a few minutes in traffic while driving	_____
Sitting quietly after lunch (no alcohol)	_____
<b>TOTAL (This is your Epworth Sleepiness score)</b>	_____

#### Past Medical History:

<ul style="list-style-type: none"> <li><input type="radio"/> Hypertension (high blood pressure)</li> <li><input type="radio"/> Heart Disease</li> <li><input type="radio"/> Pacemaker</li> <li><input type="radio"/> Stroke</li> <li><input type="radio"/> TIA "Light Stroke"</li> <li><input type="radio"/> Diabetes</li> <li><input type="radio"/> Cancer</li> <li><input type="radio"/> Lung problems    <input type="radio"/> COPD    <input type="radio"/> Asthma</li> <li><input type="radio"/> Reflux (GERD)</li> <li><input type="radio"/> Stomach / Colon problems</li> <li><input type="radio"/> Thyroid problems</li> <li><input type="radio"/> Hepatitis/jaundice</li> <li><input type="radio"/> Back or joint problems</li> <li><input type="radio"/> Arthritis</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> Hearing impairment</li> <li><input type="radio"/> Fibromyalgia</li> <li><input type="radio"/> Blackouts</li> <li><input type="radio"/> Seizures</li> <li><input type="radio"/> Depression</li> <li><input type="radio"/> Anxiety</li> <li><input type="radio"/> Alcoholism</li> <li><input type="radio"/> Chemical dependency or abuse</li> <li><input type="radio"/> <b>Female</b></li> <li><input type="radio"/> Premenstrual syndrome</li> <li><input type="radio"/> Menopause</li> <li><input type="radio"/> <b>Male</b></li> <li><input type="radio"/> Prostate problems</li> <li><input type="radio"/> Erectile dysfunction/impotence</li> </ul>
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#### List other past medical problems and dates:

_____	_____
_____	_____
_____	_____
_____	_____

#### Past Surgeries:

_____	_____
_____	_____
_____	_____

**Current Medications:**

Medication	Dose	#per day	Medication	Dose	#per day
_____	_____ mg	_____	_____	_____ mg	_____
_____	_____ mg	_____	_____	_____ mg	_____
_____	_____ mg	_____	_____	_____ mg	_____
_____	_____ mg	_____	_____	_____ mg	_____
_____	_____ mg	_____	_____	_____ mg	_____

**MEDICATION ALLERGIES:** \_\_\_\_\_

**Family History:** Has an immediate blood relative (**Father/Mother/Sister/Brother/Child**) had any of the following?

Relation	Relation
Cancer _____	Stroke _____
Diabetes _____	Anxiety/Depression _____
Hypertension _____	Sleep Apnea _____
Heart disease _____	Narcolepsy _____
Thyroid disease _____	Other: _____

**Social History:**

Marital Status: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Employment status (circle all that apply):    Employed    Unemployed    Retired    Student

Occupation: \_\_\_\_\_ My work hours are: \_\_\_\_\_

My job requires a DOT license:    YES    NO    DOT anniversary: \_\_\_\_\_

Have you ever smoked?    YES    NO    If yes, how long have you smoked? \_\_\_\_\_ Years

How much? \_\_\_\_\_ Packs per day    Have you quit smoking?    YES    NO    Year Quit \_\_\_\_\_

Do you drink alcohol?    YES    NO    If yes, how much do you feel you drink? \_\_\_\_\_ Drinks

How frequent?    DAILY    WEEKLY (\_\_\_\_ times per week)    SOCIALLY    What kind of alcohol?    BEER    LIQUOR    WINE

Do you drink caffeine?    YES    NO    Amount: \_\_\_\_\_

**Check any of the following symptoms you have had in the past 12 months:**

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input type="radio"/> Frequent headaches</li> <li><input type="radio"/> Morning headaches</li> <li><input type="radio"/> Fainting or passing out</li> <li><input type="radio"/> Sudden loss of vision or strength</li> <li><input type="radio"/> Inability to speak</li> <li><input type="radio"/> Hearing loss or ringing in ear(s)</li> <li><input type="radio"/> Hoarseness for more than 2-4 weeks</li> <li><input type="radio"/> Nosebleeds</li> <li><input type="radio"/> Cough for more than 2-4 weeks</li> <li><input type="radio"/> Coughing up blood</li> <li><input type="radio"/> Shortness of breath or wheezing</li> <li><input type="radio"/> Swelling in feet or ankles</li> <li><input type="radio"/> Chest pain, tightness or pressure</li> <li><input type="radio"/> Irregular or sudden, fast heartbeat</li> </ul> | <ul style="list-style-type: none"> <li><input type="radio"/> Frequent heartburn / indigestion</li> <li><input type="radio"/> Difficulty swallowing or food "sticking"</li> <li><input type="radio"/> Abdominal pain</li> <li><input type="radio"/> Frequent constipation</li> <li><input type="radio"/> Frequent diarrhea</li> <li><input type="radio"/> Rectal bleeding / black stools</li> <li><input type="radio"/> Difficulty urinating / incontinence</li> <li><input type="radio"/> Blood in urine</li> <li><input type="radio"/> Urinating more than 2 times per night</li> <li><input type="radio"/> Pain in joints or bones</li> <li><input type="radio"/> Unusual bruising or bleeding</li> <li><input type="radio"/> Epilepsy / seizures</li> <li><input type="radio"/> Change in wart, mole or skin growth</li> <li><input type="radio"/> Weight loss of more than 5-10 lbs.</li> </ul> |
|---|---|

**BED PARTNER QUESTIONNAIRE**

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

If you have a bed partner (or someone who observes you while sleeping), please have them complete this questionnaire.

Check any of the following behaviors that you have observed the patient doing **while asleep**:

<input type="radio"/> Loud snoring <input type="radio"/> Light snoring <input type="radio"/> Pauses in breathing <input type="radio"/> Grinding teeth <input type="radio"/> Sleep talking <input type="radio"/> Sleepwalking <input type="radio"/> Acting out of dreams	<input type="radio"/> Bedwetting <input type="radio"/> Sitting up in bed while still asleep <input type="radio"/> Head rocking or banging <input type="radio"/> Kicking or twitching of legs or feet <input type="radio"/> Getting out of bed while still asleep <input type="radio"/> Biting tongue <input type="radio"/> Becoming very rigid and/or shaking
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How long have you been aware of the sleep behavior(s) that you checked above? \_\_\_\_\_

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, how many times during the night and whether it occurs every night.

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If you have heard loud snoring, describe it in more detail. Include descriptions of any pauses in breathing or occasional loud "snorts" that you may have noticed.

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OFFICE USE ONLY				
<input type="checkbox"/> Snoring – R06.83 <input type="checkbox"/> OSA - G47.33 <input type="checkbox"/> CSA - G47.31 <input type="checkbox"/> EDS – G47.13 <input type="checkbox"/> Hypoxia – G47.36 <input type="checkbox"/> Hypoxemia – R09.02 <input type="checkbox"/> RLS – G25.81 <input type="checkbox"/> PLMD – G47.61 <input type="checkbox"/> Parasomnia – G47.59 <input type="checkbox"/> RBD – G47.52	<input type="checkbox"/> Fragmented sleep – G47.8 <input type="checkbox"/> Fatigue – R53.83 <input type="checkbox"/> Insomnia – G47.09 <input type="checkbox"/> Inadeq Sleep Hyg – Z72.821 <input type="checkbox"/> Insuff Sleep – F51.12 <input type="checkbox"/> Shiftwork – G47.26 <input type="checkbox"/> Narcolep; cata – G47.411 <input type="checkbox"/> Narcolep; no cata – G47.419	<input type="checkbox"/> Palpitations – R00.2 <input type="checkbox"/> Arrhythmia – I49.9 <input type="checkbox"/> HTN – I10 <input type="checkbox"/> T2DM – E11.9 <input type="checkbox"/> GERD – K21.9 <input type="checkbox"/> ↑ Hb – R71.8 <input type="checkbox"/> ↑ Tonsils – J35 <input type="checkbox"/> COPD – J44.9	<input type="checkbox"/> ↓ Memory – R41.3 <input type="checkbox"/> Depression – F33.8 <input type="checkbox"/> Anxiety – F41.1 <input type="checkbox"/> ADHD – F90.9 <input type="checkbox"/> Bipolar – F31.9  <input type="checkbox"/> Obesity – E66.9 <input type="checkbox"/> Morb Obesity – E66.01	<input type="checkbox"/> 95806 HST <input type="checkbox"/> 95810 DX ONLY <input type="checkbox"/> 95811 SPLIT NIGHT <input type="checkbox"/> 95811 1 <sup>ST</sup> .TX CPAP <input type="checkbox"/> 95811 Re.Attempt <input type="checkbox"/> 95811 RE.TX CPAP <input type="checkbox"/> 95811 RE.TX BIPAP <input type="checkbox"/> 95811 RE.TX ASV <input type="checkbox"/> 99215 DSOV <input type="checkbox"/> PAP Order <input type="checkbox"/> 7-Night Noc Ox <input type="checkbox"/> DME Switch <input type="checkbox"/> Dr L <input type="checkbox"/> PCP <input type="checkbox"/> Fe++ <input type="checkbox"/> Rx <input type="checkbox"/> DDS <input type="checkbox"/> ENT

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Heart Rate / Pulse: \_\_\_\_\_ O2 Saturation: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_