Name: _____ Date of Birth: _____/_____/_____

Pacific Sleep Program

Portland & Astoria

Setting the standard in sleep medicine for over 30 years

PATIENT QUESTIONNAIRE

Hello,
You have been referred to the Pacific Sleep Program sleep clinic. Our experienced team of physicians, affiliated clinicians, sleep technologists and staff are dedicated to helping you with your sleep issues.

Please take a few minutes to fill out this questionnaire before you see the clinician.
We look forward to seeing you.

The Pacific Sleep Program Staff

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? Even if you have not done some of these things recently, try to work out how these situations would have affected you.

0- **NEVER** doze
1- **SLIGHT** chance of dozing
2- **MODERATE** chance of dozing
3- **HIGH** chance of dozing

Situation	Chance of dozing (0-3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when the circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Please answer the following questions to the best of your ability:

What is the main reason for your visit? _____

Have you seen a physician before about your sleep or alertness problem? YES NO

Have you had a previous sleep test before? YES NO

If yes, when and where: _____

Have you ever been diagnosed with the following sleep disorder(s)?

Sleep Apnea Restless Leg Syndrome Narcolepsy Other: _____

Occupation: _____ Do you work shift work? YES NO

Typical work schedule: _____

Do you work with hazardous material or heavy machinery? YES NO

Do you have a commercial driver's license (truck, bus, etc.) or Pilot's license? YES NO

Please complete the following questions about your sleep patterns and tiredness levels as best as you can. You may, if you wish, have a bed partner/family member complete this with you.

Time you usually/most commonly turn out the lights to go to bed: _____

Time it usually takes you to fall asleep after lights out: _____

How many times do you usually wake up out of sleep, even if just momentarily? _____

Once you awaken during the night, how long does it typically take to fall back asleep? _____

What time do you usually finally awaken from sleep? _____

How many hours of sleep do you estimate that you usually get? _____

Does your sleep schedule vary on the weekends? YES NO

If yes, please describe: _____

Do you nap? YES NO

If yes, how frequently do you nap? _____ How long are your naps? _____

Do you feel more refreshed after your naps? YES NO

Do you consider yourself a: Morning Person/ "Early Bird" Evening Person/ "Night Owl" Neither

Please rate and place an "X" for one of the three options that best fits.

	Seldom/ never	Sometimes/ moderate	Usually/ always
Do you feel that your sleep is unrefreshing?			
Is your sleep area cool, dark and quiet?			
Are you bothered by outside lights/noises when you sleep?			
Do you watch TV or use electronic devices (computer, tablets, etc.) before bed?			
Do you lie awake at night with your mind "racing," worried or depressed?			
Do pain issues disturb your sleep?			

Do you use pills (either prescription or over-the-counter) to help you sleep? YES NO

If yes, please describe: _____

Do you use alcohol or other controlled substances to help you sleep? YES NO

What body positions do you sleep in?

BACK STOMACH SIDES RECLINED HEAD OF BED ELEVATED

	Seldom/ never	Sometimes/ moderate	Usually/ always
Have you been told that you snore?			
Have you been told that you snore loudly and bother others?			
Have you been told that you appear to stop breathing during sleep?			
Are you aware yourself of choking or gasping awake during sleep?			
Do you awaken with your mouth or throat dry and irritated?			
Do you awaken with voice hoarseness?			
Do you have bothersome nasal congestion during sleep?			

Do you have a bed partner? YES NO

If YES, please answer the following questions:

	Seldom/ never	Sometimes/ moderate	Usually/ always
Does your bed partner "elbow" you to change positions during sleep?			
Does your bed partner use earplugs or leave the room due to your snoring?			

Do you awaken from sleep for urination? YES NO If so, how many times? _____

	Seldom/ never	Sometimes/ moderate	Usually/ always
Do you awaken from sleep for heartburn (reflux or GERD)?			
Do you awaken from sleep with night sweats?			
Do you awaken from sleep with a headache?			
Do you awaken from sleep with chest pain or heart racing?			
Are you aware or has a dentist told you that you grind your teeth during sleep?			

	Seldom/ never	Sometimes/ moderate	Usually/ always
Are you drowsy or sleepy during your regular wake hours?			
Do you have problems with memory or concentration?			
Have you gotten in trouble at school/work due to fatigue/sleepiness?			
Have you had trouble with your personal/social life due to fatigue/sleepiness?			
Have you been injured because of fatigue/sleepiness?			
Do you use coffee/caffeine drinks/stimulants to stay alert?			
Do you feel sleepy when driving?			
Have you had any driving accidents or “close calls” due to fatigue?			

Do you experience persistent, uncomfortable feelings in your legs while sitting/lying down? YES NO

If YES, please answer the following questions:

	Yes	No
Is there a persistent urge to move your legs?		
Are these uncomfortable feelings or urges to move your legs worse in the evening or night as compared with the morning?		
Do they disappear or improve when you are active or moving around?		

How often do leg movements disturb your ability to fall asleep? _____ Times per week

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	Yes	No
Do you twitch or make sudden jerking movements during sleep?		
Do you awaken yourself or your bed partner by kicking during sleep?		
Do you walk in your sleep or have periods of confusion during sleep?		
Do you do violent or destructive things during sleep, such as acting out dreams?		
Do you have frequent or repetitive frightening dreams or nightmares?		
Do you experiencing bedwetting?		
Do you have a history of seizures during sleep?		
Have you heard voices or seen visions as you drift into or awaken from sleep?		
Do you awaken from sleep unable to move or speak- as if paralyzed- yet feeling that you are awake?		
Do you have attacks of physical weakness (actual loss of muscle control) when laughing, crying, or during other emotional situations?		

MEDICAL HISTORY – Please circle all those that apply to you.

Atrial Fibrillation	Asthma	Anemia
Cardiac Arrhythmia	Allergies	Chronic Kidney Disease
Coronary Artery Disease	Chronic Nasal/Sinus Issues	Kidney Stones
Hypertension	Chronic Neck Pain	Acid Reflux/Heartburn
Heart Attack	Chronic Back Pain	Irritable Bowel Syndrome
Congestive Heart Failure	Anxiety Disorder	Liver Disease
Heart Murmur/Valve Problems	Depression	Hypothyroidism
Goiter	Bipolar Disorder	Hyperthyroidism
Chronic/Frequent Headaches	Schizophrenia	Thyroid Disease
Head Injury	Drug Abuse	Alcohol Abuse
Glaucoma	Fibromyalgia	High Cholesterol
Seizures	Chronic Fatigue Syndrome	Diabetes Mellitus
Multiple Sclerosis	Prostate Enlargement	Stroke
Post-traumatic Stress Disorder (PTSD)	Erectile/Sexual Dysfunction	COPD/Emphysema
Attention Deficit Disorder (ADD)	Osteoporosis	Other Kidney Disease
Other:		

SURGICAL HISTORY – Please circle all those that apply to you.

Nasal/Sinus Surgery	Pacemaker	Appendectomy
Palatoplasty/UPPP	Heart Valve Replacement	Gallbladder Removal
Septoplasty	Tracheostomy	Hysterectomy
Tonsillectomy/Adenoidectomy	Thyroid Surgery	Cosmetic Surgery
Jaw Surgery/Maxillary Surgery	Bariatric Surgery	Wisdom Teeth Removal
Brain Surgery	Ovary Removal	Cardiac Bypass
Spine Surgery	Hernia Repair	Joint Replacement
Eye Surgery	Cardiac Stent	Other:

FAMILY HISTORY – Please place an "X" in the space that best fits.

☐ Family history unknown

Relationship	Sleep Apnea	Suspected Sleep Apnea	Insomnia	Restless Leg Syndrome	Narcolepsy	High Blood Pressure	Heart Disease	Stroke
Mother								
Father								
Sister								
Brother								
Daughter								
Son								
Other								

GENERAL HISTORY – Please circle the following you have problems with:

General	**Cardiovascular**	**Musculoskeletal**	**Psychiatric**
Weight loss	Chest pain	Joint pain	Suicidal thoughts
Weight gain	Swelling of the ankles	Muscle pain	History of mental abuse
Eyes	**Immunologic**	**Skin**	History of physical abuse
Dry eyes	Fevers, chills	Rash	History of sexual abuse
Ears/Nose/Throat/Neck	**Gastrointestinal**	**Endocrine**	Anxiety
Nose bleeds	Difficulty swallowing	Heat intolerance	Claustrophobia
Dry nose	Bloating	Cold intolerance	**Neurologic**
Nasal polyps	Constipation	Menstrual disorder	Numbness or tingling
Deviated septum		Postmenopausal	Memory Loss
Jaw pain or clicking	**Respiratory**	**Hematologic**	Tremor
Dentures	Chronic cough	Abnormal bleeding	Loss of Balance
No teeth	Shortness of breath	Abnormal bruising	Ringing of the ears
Gum disease	Chest tightness		Hearing loss
Over-bite	On oxygen therapy		Dizziness
Under-bite	**Urologic**		Fainting
	Urinary Incontinence		Headaches

SOCIAL HISTORY

Do you drink alcohol? YES NO

If so, how many alcoholic drinks do you have during the week?

_____Glasses of wine _____Cans of beer _____Shots of liquor

Do you use recreational drugs? YES NO

If yes, which types and how often per week? _____

Do you use medical marijuana? YES NO

If yes, how many times throughout the week?_____

Do you use tobacco products, including smokeless tobacco? YES NO

If yes, how many packs per day and for how long? _____

If no, have you ever smoked? YES NO

How much of the following do you drink?

	In a usual 24 hour period	Within 6 hours of going to bed
Coffee		
Caffeinated tea		
Soda/Pop		
Energy drinks		

Do you exercise? If so, what type and how frequently? _____

Please list all your current medications and dosages (including non-prescription medications):

_____ _____

_____ _____

_____ _____

_____ _____

Name and location of preferred/current pharmacy: _____

Have you travelled outside the US in the last 30 days? If so, where? _____

Do you have allergies to medications? YES NO

If yes, please list and explain below:

Medication/Substance Reaction

_____ _____

_____ _____