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

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

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

Please list physicians you would like to receive a copy of your sleep study results:

	Name
1.	
2.	
3.	

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: _____

Work

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

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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.

	Bedtime	Rise time	How long to fall asleep
Typical sleep schedule on work days	____:____	____:____	_____
Typical sleep schedule on days off	____:____	____:____	_____

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? _____

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

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) or other substances 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 ☐ IN RECLINER ☐ 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? If yes, do you wear a night guard? ☐ Yes ☐ No			
	Seldom/ never	**Sometimes /moderate**	**Usually/ always**
Are you drowsy or sleepy during your regular wake hours?			
Do you have problems with memory or concentration?			
Are you more irritable than you use to be?			
Have you felt more depressed or more anxious?			
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 and/or arms while sitting/lying down? ☐ Yes ☐ No

Do unpleasant feelings in your legs make it difficult for you to get to sleep or awaken you at night? ☐ Yes ☐ No

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

Do you twitch or make sudden jerking movements during sleep? ☐ Yes ☐ No

Do you awaken yourself or your bed partner by kicking during sleep? ☐ Yes ☐ No

	Yes	No
Have you been told, as an adult, that you sleep walk or have periods of confusion during the night?		
Do you act out dreams during sleep?		
Do you have frequent or repetitive frightening dreams or nightmares?		
Have you wet the bed during sleep as an adult?		
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 check all those that apply to you.

☐ None

☐ Atrial Fibrillation	☐ Multiple Sclerosis	☐ Fibromyalgia	☐ Hyperthyroidism
☐ Cardiac Arrhythmia	☐ Diabetes Mellitus	☐ Chronic Fatigue Syndrome	☐ Thyroid Disease
☐ Coronary Artery Disease	☐ COPD/Emphysema	☐ Allergies	☐ Goiter
☐ Hypertension	☐ High Cholesterol	☐ Asthma	☐ Osteoporosis
☐ History of Heart Attack	☐ Post- traumatic Stress Disorder (PTSD)	☐ Chronic Nasal/Sinus Issues	☐ Glaucoma
☐ Congestive Heart Failure	☐ Attention Deficit Disorder (ADD)	☐ Benign Prostate Enlargement	☐ Chronic Back Pain
☐ Heart Murmur/Valve Problems	☐ Anxiety Disorder	☐ Anemia	☐ Chronic Neck Pain
☐ History of Stroke	☐ Depression	☐ Kidney Stones	☐ Other: Please list in spaces below
☐ Migraine or Headache disorder	☐ Bipolar Disorder	☐ Acid Reflux/Heartburn	1.)
☐ History of Head Injury	☐ Schizophrenia	☐ Irritable Bowel Syndrome	2.)
☐ History of concussion	☐ Alcohol Abuse (current or past)	☐ Liver Disease	
☐ Seizures	☐ Drug Abuse (current or past)	☐ Hypothyroidism	.

SURGICAL HISTORY – Please check all those that apply to you. ☐ No previous surgeries

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

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

☐ Family history unknown ☐ No family history of sleep or cardiovascular disorders

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 check off the following you have problems with: ☐ None

General	Cardiovascular	Musculoskeletal	Hematologic
☐ Weight loss	☐ Chest pain	☐ Joint pain	☐ Abnormal bleeding
☐ Weight gain	☐ Swelling of the ankles	☐ Muscle Pain	☐ Abnormal bruising
Eyes	**Immunologic**	**Skin**	
☐ Dry eyes	☐ Unexplained fevers	☐ Rash	
Respiratory	**Gastrointestinal**	**Endocrine**	**Genitourinary**
☐ Chronic cough	☐ Difficulty swallowing	☐ Heat intolerance	☐ Urinary Incontinence
☐ Shortness of breath	☐ Bloating	☐ Cold intolerance	☐ Erectile or sexual dysfunction
☐ Chest tightness	☐ Constipation		☐ Menstrual disorder

☐ On oxygen therapy	☐ Post menopausal

GENERAL HISTORY CONTINUED…

Ear/Nose/Throat/Neck	Neurologic	Psychiatric
☐ Nose bleeds	☐ Numbness or tingling	☐ History of suicidal thoughts
☐ Dry nose	☐ Tremor	☐ History of mental abuse
☐ Nasal polyps	☐ Loss of balance	☐ History of physical abuse
☐ Deviated septum	☐ Ringing of the ears	☐ History of sexual abuse
☐ Jaw pain or clicking	☐ Hearing loss	☐ Claustrophobia
☐ Dentures	☐ Dizziness	
☐ No teeth	☐ Fainting	
☐ Gum disease		
☐ Overbite		
☐ Underbite		

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

If Yes, quit date: ___/___/____

How much of the following do you drink?

	In a usual 24-hour period	Within 6 hours of going to bed
Caffeinated coffee		
Caffeinated tea		
Caffeinated soda/pop		
Caffeinated energy drinks		

Do you exercise? ☐ Yes ☐ No

If so, what type and how frequently? _____

Medications

Name of preferred pharmacy:_____

Location of pharmacy:_____

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

MEDICATION	DOSAGE
1.)	
2.)	
3.)	
4.)	
5.)	
6.)	
7.)	
8.)	
9.)	
10.)	

Have you travelled outside the US in the last 30 days? ☐ Yes ☐ No

If so, where? _____

Do you have allergies to medications? ☐ Yes ☐ No

If yes, please list and explain below:

Medication/Substance	Reaction	Medication/Substance	Reaction
1.)		4.)	
2.)		5.)	

3.)		6.)	

Breathing Screening Questionnaire

*Complete if 35+ years old

This survey asks questions about you, your breathing and what you are able to do. To complete the survey, mark an X in the box that best describes your answer for each question below.

1) During the past few weeks, how much of the time did you feel short of breath?

☐ None of the above	☐ A little of the time	☐ Some of the time	☐ Most of the time	☐ All of the time
(0)	(0)	(1)	(2)	(2)

2) Do you ever cough up any "stuff", such as mucus or phlegm?

☐ No, never	☐ Only with occasional cold or chest infections	☐ Yes, a few days a month	☐ Yes, most days a week	☐ Yes, everyday
(0)	(0)	(1)	(1)	(2)

3) Please select the answer that best describes you in the past 12 months. I do less than I use to because of my breathing problems.

☐ Strongly disagree	☐ Disagree	☐ Unsure	☐ Agree	☐ Strongly agree
(0)	(0)	(0)	(1)	(2)

4) Have you smoked at least 100 cigarettes in your entire life?

☐ No	☐ Yes	☐ Don't know
(0)	(2)	(0)

5) How old are you?

☐ Age 35-49	☐ Age 50-59	☐ Age 60-69	☐ Age 70+
(0)	(1)	(2)	(2)