



Pacific Sleep Program

Portland & Astoria

*Setting the standard in sleep
medicine for over 35 years*

NEW PATIENT QUESTIONNAIRE

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, give a general estimate for each situation.

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

	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 the physicians who should receive a copy of your sleep study results:

1.	2.
----	----

Have you had a previous sleep test? Yes No

If **Yes**, when and where: _____

Have you ever been diagnosed with any of 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

SLEEP PATTERNS

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

	Bedtime	Rise time	How long it takes you 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?

< 15 minutes 15–30 minutes 30–60 minutes 1+ hours

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

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

SLEEP PATTERNS (CONT.)

Please answer the following questions by placing an “X” under the option that best fits.

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

Do you use pills (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? Check all that apply.

On my back On my stomach On my sides In a recliner With the head of the bed elevated

Do you have a bed partner? Yes No

If **Yes**, please answer the following questions by placing an “X” under the option that best fits:

	Seldom/ never	Sometimes	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?			

Please answer the following questions by placing an “X” under the option that best fits.

	Seldom/ never	Sometimes	Usually/ always
Have you been told (by anyone) 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 of choking or gasping awake during sleep?			
Do you awaken with your mouth or throat dry and irritated?			
Do you have bothersome nasal congestion during sleep?			

SLEEP PATTERNS (CONT.)

Do you awaken from sleep for urination? Yes No If **Yes**, how often? _____ times/night

Please answer the following questions by placing an “X” under the option that best fits.

	Seldom/ never	Sometimes	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 your heart racing?			
Are you aware of grinding your teeth during sleep, or has a dentist told you that you do this?			

If **Yes**, do you wear a night guard? Yes No

	Seldom/ never	Sometimes	Usually/ always
Are you drowsy or sleepy during your regular awake hours?			
Do you have problems with memory or concentration?			
Lately, have you felt more depressed or more anxious?			
Have you been injured because of fatigue or sleepiness?			
Do you use coffee, caffeine drinks, or 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 or lying down?			
Do unpleasant feelings in your legs make it difficult for you to get to sleep or awaken you at night?			
Do you twitch or make sudden jerking movements during sleep?			
Do you awaken yourself or your bed partner by kicking during sleep?			

SLEEP PATTERNS (CONT.)

- Have you been told, as an adult, that you sleepwalk or have awoken with periods of confusion or disorientation during the night? Yes No
- Do you act out dreams (with vigorous arm or leg movements) during sleep? Yes No
- Do you have frequent or repetitive frightening dreams or nightmares? Yes No
- Have you wet the bed during sleep as an adult? Yes No
- Do you have a history of seizures during sleep? Yes No
- Have you heard voices or seen visions as you drift into or awaken from sleep? Yes No
- Do you awaken from sleep unable to move or speak (as if you are paralyzed), yet you feel like you are awake? Yes No
- Do you have attacks of physical weakness (actual loss of muscle control) when laughing or crying, or during other emotional situations? Yes No

MEDICAL HISTORY

Please check all that apply to you.

None

<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> Overweight/obesity	<input type="checkbox"/> Chronic nasal or sinus issues	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Cardiac arrhythmia	<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> Benign prostate enlargement	<input type="checkbox"/> Chronic pain
<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> COPD or emphysema	<input type="checkbox"/> Anemia	<input type="checkbox"/> TMJ or jaw problems
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> On supplemental oxygen therapy	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> History of orthodontic treatment (braces)
<input type="checkbox"/> History of heart attack	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Erectile dysfunction	<input type="checkbox"/> Alcohol abuse (current or past)
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Post-traumatic stress disorder (PTSD)	<input type="checkbox"/> Acid reflux or heartburn	<input type="checkbox"/> Drug abuse (current or past)
<input type="checkbox"/> Heart murmur or valve problems	<input type="checkbox"/> Attention deficit disorder (ADD)	<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Tobacco use (current or past)
<input type="checkbox"/> History of stroke	<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Other: Please list in the spaces below
<input type="checkbox"/> Migraine or headache disorder	<input type="checkbox"/> Depression	<input type="checkbox"/> Hypothyroidism	1.
<input type="checkbox"/> History of head injury	<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Hyperthyroidism	2.
<input type="checkbox"/> History of concussion	<input type="checkbox"/> Allergies	<input type="checkbox"/> Goiter	3.
<input type="checkbox"/> Seizures	<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	4.

SURGICAL HISTORY

Please check all that apply to you.

No previous surgeries

<input type="checkbox"/> Nasal or sinus surgery	<input type="checkbox"/> Spine surgery	<input type="checkbox"/> Cardiac stent	<input type="checkbox"/> Other: Please list in the spaces below
<input type="checkbox"/> Palatoplasty/UPPP	<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Cardiac bypass	1.
<input type="checkbox"/> Septoplasty	<input type="checkbox"/> Thyroid surgery	<input type="checkbox"/> Hysterectomy	2.
<input type="checkbox"/> Tonsillectomy and/or adenoidectomy	<input type="checkbox"/> Bariatric surgery	<input type="checkbox"/> Cosmetic surgery	3.
<input type="checkbox"/> Jaw or maxillary surgery	<input type="checkbox"/> Brain surgery	<input type="checkbox"/> Wisdom teeth removal	4.

FAMILY HISTORY

Family history unknown

No family history of sleep or cardiovascular disorders

If you didn't check either box, please complete the table below.

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

SOCIAL HISTORY

Do you drink alcohol?

Yes No

If **Yes**, 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? _____

SOCIAL HISTORY (CONT.)

Do you use tobacco products, including smokeless tobacco? Yes No

If **Yes**, how many packs or cans per day and for how long? _____

If **No**, have you ever smoked? Yes No

If **Yes**, when did you quit? ___/___/___

(if you can't remember the exact date, give your best approximation)

Do you drink caffeinated beverages? Yes No

If **Yes**, how much of the following beverages do you drink?

	In a usual 24-hour period	Within 6 hours of going to bed	I don't drink this caffeinated beverage
Caffeinated coffee	___ cups	___ cups	
Caffeinated tea	___ cups	___ cups	
Caffeinated soda or pop	___ bottles/cans	___ bottles/cans	
Caffeinated energy drinks	___ drinks	___ drinks	

Do you exercise? Yes No

If **Yes**, what type of exercise and how frequently? _____

MEDICATIONS

Name of and location of preferred pharmacy: _____

Please list all of your current medications and dosages, including non-prescription medications.

Medication	Dosage	Medication	Dosage
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

MEDICATIONS (CONT.)

Do you have allergies to any medications or substances (e.g., latex)?

Yes No

If **Yes**, please list each medication or substance you are allergic to and explain how you react to it below:

Medication/Substance	Reaction	Medication/Substance	Reaction
1.		3.	
2.		4.	