NH1663

NORTHSIDE HOSPITAL

SLEEP DISORDERS CENTER

ADDRESSOGRAPH

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

INSTRUCTIONS FOR COMPLETING QUESTIONNAIRE

While a thorough history will be verified when you arrive for your appointment, answering this questionnaire will assist in the diagnostic process. Please print, fill out and bring the completed form with you to your appointment.

GENERAL INFORMATION

Name: _____

Date of Birth: _____ /_____ /_____ Age:_____ Marital Status: M ❑ S ❑ W ❑ D ❑

Address: _____
Street Apt. #

_____
City State Zip Code

Home #: ( ) _____ Work #: ( ) _____ Cell #: ( ) _____

Height: _____ Weight: _____ Sex: M ❑ F ❑ Collar Size: _____

Occupation: _____ Years on Job: _____ Shift: _____

Referral Source: Physician ❒ TV ❒ Magazine ❒ Friend/Family ❒ Health Fair ❒ Other ❒_____

Name of Referring Physician: _____

Phone #: _____

Please state in your own words the reason (s) you or your doctor contacted the Sleep Disorders Center:

_____

_____

_____

_____

Have you been evaluated for this problem? Yes ❒ No ❒

Have you been treated for this problem? Yes ❒ No ❒ If yes, what treatments _____

Have you had a previous sleep study? Yes ❒ No ❒ If yes, when and where_____

1. On average, how many hours of sleep do you get each night? _____hrs. _____min
2. How long does it usually take you to fall asleep? ____hrs. _____ min
3. Have anxiety (worry about things) while falling asleep? Yes ❒ No ❒
4. Feel unable to move upon awakening? Yes ❒ No ❒
5. Have creeping, crawling, aching or twitching feelings in your legs (feel like you have to move them)? Yes ❒ No ❒
6. Have vivid, dream-like scenes even though you know you are not totally asleep? Yes ❒ No ❒
7. Have any kind of pain or discomfort that interferes with sleep? Yes ❒ No ❒
   Please describe pain: _____
   Location: _____
   Intensity (0-10 scale): 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
   Frequency (how often does it occur?): _____
   What relieves it: _____

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8. Check one box for each statement - Do you:	**Yes**	**No**
a. sleep with someone else in your bed?	❒	❒
b. get up at night to attend to your children or something else?	❒	❒
c. been told you snore loudly?	❒	❒
d. feel your heart pounding during the night?	❒	❒
e. sweat a lot during the night?	❒	❒
f. walk in your sleep?	❒	❒
g. have unusual movements while asleep?	❒	❒
h. grind your teeth at night?	❒	❒
i. feel sleepy during the day?	❒	❒
j. fall asleep unintentionally? Please give an example: _____.	❒	❒
k. feel sad or depressed or anxious during the day?	❒	❒
l. feel weakness in your muscles when laughing, surprised, angry, excited, etc.?	❒	❒
m. take naps during the day?	❒	❒
n. travel frequently or do shift work?	❒	❒
o. choke, gasp or stop breathing during sleep or been told you do?	❒	❒

OTHER QUESTIONS

9. Does anyone in your family have a sleep problem? Yes ❒ No ❒

Relationship to You	**Describe the problem**
_____	_____
_____	_____

10. How much of the following fluids do you drink within 3 hours before bedtime?
    a. Coffee: caffeinated _____ Cups
       decaffeinated _____ Cups
    b. Tea _____ Cups
    c. Soda _____ Cans
    d. Beer _____ Cans
    e. Wine _____ Glasses
    f. Other alcoholic beverages _____ Glasses

11. How much tobacco do you smoke during a 24-hour period? _____

12. Please list the name and dose (in mg.) of all medications you take now or within the past 30 days:

Medication	Dose	What is it for?
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____
d. _____	_____	_____
e. _____	_____	_____
f. _____	_____	_____

13. Please list the name of any pill for sleeping or staying awake that you have taken in the **PAST:**

Name of Pill	**Did it Help?**
a. _____	Yes ❒ No ❒
b. _____	Yes ❒ No ❒
c. _____	Yes ❒ No ❒
d. _____	Yes ❒ No ❒

14. How many times each week do you participate in a sport or partake in some form of exercise _____?

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HEALTH HISTORY

Please check any problem or illness you have now, or have had in the past:

❒ Heart Disease	❒ High Blood Pressure	❒ Heart Attack
❒ Low Blood Pressure	❒ Fainting	❒ Dizziness
❒ Headaches	❒ Ringing of the Ears	❒ Epilepsy
❒ Black Outs	❒ Hemophilia (Bleeder)	❒ Ulcers
❒ Hernia	❒ Prostate Trouble	❒ Mental Problems
❒ Back Trouble	❒ Gout	❒ Seizures
❒ Asthma	❒ Allergies	❒ Bronchitis
❒ Cancer	❒ Kidney Trouble	❒ Bladder Trouble
❒ Eye Trouble	❒ Hearing Trouble	❒ Pneumonia
❒ Meningitis	❒ Heartburn	❒ Impotence
❒ Depression	❒ Venereal Disease	❒ Arthritis
❒ Tuberculosis	❒ Muscle Cramps	

SURGERIES & HOSPITALIZATIONS

Please list any hospitalizations and / or surgeries you have had. PLACE THE LATEST FIRST and include where, what, why, and when.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

15. Do you have any special needs (oxygen, wheelchair, visually/hearing impaired, etc.)?

_____

_____

_____

_____

_____

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BED PARTNER QUESTIONNAIRE

Name of Patient: _____

Name of Person Filling Out This Form: _____

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

- ❒ Light Snoring
- ❒ Loud Snoring
- ❒ Occasional Loud Snorts
- ❒ Choking
- ❒ Pauses in Breathing
- ❒ Twitching or Kicking of Legs During Sleep
- ❒ Grinding Teeth
- ❒ Sleepwalking
- ❒ Twitching or Jerking of Arms During Sleep
- ❒ Bed Wetting
- ❒ Biting Tongue
- ❒ Getting Out of Bed but Not Awake
- ❒ Crying Out
- ❒ Sitting Up in Bed Not Awake
- ❒ Mental Problems
- ❒ Awakening with Pain
- ❒ Head Rocking or Banging
- ❒ Seizures
- ❒ Becoming Very Rigid and/or Shaking
- ❒ Apparently Sleeping Even if she/he Behaves Otherwise
- ❒ Bronchitis
- ❒ Other: _____

Please describe the sleep behaviors checked in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

_____

_____

_____

_____

_____

_____

_____

_____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations such as driving? ❑ Yes ❑ No

If yes, please explain: _____

_____

_____

_____

_____

_____

_____

_____

_____

Bed Partner Signature _____ Date _____