Physicians' Clinic of Iowa, P.C.

SLEEP MEDICINE NEW PATIENT QUESTIONNAIRE

Date of first appointment ____________ First Name ____________ Last Name ____________

Date of Birth ____________ Age ______ Gender: ☐ Male ☐ Female

FAMILY HISTORY:

Did anyone in your immediate family (mother, father, brother, sister) suffer from any of the following?

☐ Sleep Apnea ☐ Narcolepsy ☐ Restless Leg Syndrome ☐ Early Cardiac Death

SLEEP HISTORY:

☐ Yes ☐ No Feeling sleepy during the day
☐ Yes ☐ No Snoring
☐ Yes ☐ No Awakened by your own snoring
☐ Yes ☐ No Wake up gasping for air
☐ Yes ☐ No Stop breathing while asleep
☐ Yes ☐ No Restless sleep
☐ Yes ☐ No Sleep walking
☐ Yes ☐ No Talking while asleep
☐ Yes ☐ No Episodes of confusion
☐ Yes ☐ No Have vivid dreams/nightmares
☐ Yes ☐ No Have morning headaches
☐ Yes ☐ No Heartburn/gastric reflux at night
☐ Yes ☐ No Limb jerks while asleep
☐ Yes ☐ No An urge to move your legs
☐ Yes ☐ No A creepy, crawly feeling in legs

Do you work? ☐ Yes ☐ No (If no, please still complete your typical bedtime and rise time, as well as how long it typically takes you to fall asleep.)

What is your typical sleep schedule on **work** days? Bedtime: ____________ AM / PM Rise Time: ____________ AM / PM

What is your typical sleep schedule on **non-work** days? Bedtime: ____________ AM / PM Rise Time: ____________ AM / PM

How long does it take you to fall asleep on **work** days? ____________ On **non-work** days? ____________

If you have difficulty falling asleep, do you? ☐ Watch TV ☐ Read ☐ Toss & Turn ☐ Worry

Any other activities you do while trying to fall asleep? ____________

How many times do you wake up at night?____________ How many of those are restroom visits? ________

How long does it take you to go back to sleep?____________

Do you feel excessively sleepy in the daytime? ☐ Yes ☐ No Are you typically refreshed after sleep? ☐ Yes ☐ No

Do you nap during the day? ☐ Yes ☐ No If yes, for how often and for how long? ____________

Have you ever felt weak in your muscles when laughing, angry, or other emotions? ☐ Yes ☐ No

Have you seen or heard people or things when waking up or falling asleep that weren't there? ☐ Yes ☐ No

Have you felt like you can't move when waking up or falling asleep? ☐ Yes ☐ No

EPWORTH SLEEPINESS SCALE: Please estimate your risk of falling asleep in the following situations, using the scale below:

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

0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Have you had a sleeping problem diagnosed in the past? ☐ Yes ☐ No

If yes, what was the problem and what treatment was recommended?____________

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