



**Millennium Respiratory and Sleep Disorders Specialist
The Woodlands, TX**

PATIENT DEMOGRAPHICS

DATE _____

PATIENT'S NAME _____

DATE of BIRTH _____

EMAIL _____

SEX _____ **HEIGHT** _____ **WEIGHT** _____ **NECK SIZE** _____

ADDRESS _____

CITY, STATE, ZIP _____

HOME PHONE # _____

BUSINESS PHONE # _____

CELL/PAGE # _____

OCCUPATION _____

DOCTOR _____

REASON FOR STUDY _____

Chief Complaints (symptoms that lead you to believe you have a sleep disorder):

Have you ever had a sleep study done before? _____ If yes, when? _____

Are you currently on CPAP/BIPAP? _____ If yes, what pressure? _____



DIAGNOSTICS AND TREATMENT SLEEP QUESTIONNAIRE

Name: _____ DOB: _____ Age: _____ Height: _____ ft. _____ in Weight: _____ lbs.

Referring Physician: _____ Neck or collar size: _____ in.

1. If this is someone other than the patient filling out this form, please indicate your relationship to the patient:

2. My sleep is frequently disturbed by: (check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Holding Breath | <input type="checkbox"/> Nasal Congestion |
| <input type="checkbox"/> Choking /Coughing/ Gasping | <input type="checkbox"/> Indigestion or Heartburn | <input type="checkbox"/> Heat/Cold |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Waking Up Feeling Paralyzed | <input type="checkbox"/> Ambient Light/Noise |
| <input type="checkbox"/> Hunger | <input type="checkbox"/> Bed Partner/Children/Pets | <input type="checkbox"/> Frequent Need to Urinate |
| <input type="checkbox"/> Creeping/Crawling Feelings in Legs | <input type="checkbox"/> Kicking/Twitching | <input type="checkbox"/> Tossing/Turning |
| <input type="checkbox"/> Teeth Grinding/ Jaw Pain | <input type="checkbox"/> Trouble Falling/Staying Asleep | <input type="checkbox"/> Sleep Walking/Talking |
| <input type="checkbox"/> Nocturnal Enuresis (Bed Wetting) | <input type="checkbox"/> Feeling tired and sleepy during the day | <input type="checkbox"/> Dry Mouth/ Thirst |
| <input type="checkbox"/> Vivid Dreams (Dreaming in Color) | <input type="checkbox"/> Acting Out Dreams | <input type="checkbox"/> Nightmares |

3. Have you ever had a sleep study? Yes No
If so, when and where? _____

4. Are you currently on CPAP therapy? Yes No
If so:
• What pressure are you presently using? _____ cm
• Does the mask fit OK? Yes No
• Do you use it every night? Yes No

5. Have you recently lost or gained weight? Yes No
If so, how much? Lost Gained _____ lbs.

6. Do you smoke? Yes No
If so, how much and for how long? _____ Cigarettes _____ Day _____ Years

7. Do you consume alcoholic beverages? Yes No If so, how much _____

8. Do you consume caffeinated beverages? Yes No If so, how much _____



9. Please check all major medical problems:

- | | | | | |
|------------------------------------|--|--|-------------------------------------|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Depression/ Anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Opioid Dependence |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> TMJ/ Bruxism | <input type="checkbox"/> Impotence | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Reflux/GERD | <input type="checkbox"/> Fainting/Black Outs | <input type="checkbox"/> Stroke | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Cancer | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fibromyalgia |

Please list any illness not listed above:

10. Please list ALL medications you take including over the counter: *(Circle any medications you take before bed)*

11. Are you allergic to any drugs? Yes No If yes, please list: _____

12. Have you had nasal or sinus surgery? Yes No If yes, please describe: _____

YOUR SLEEP PATTERNS:

1. What time do you usually go to bed? Weekdays: _____ : _____ Weekends: _____ : _____

2. What time do you usually wake up? Weekdays: _____ : _____ Weekends: _____ : _____

3. Do you have Insomnia? Yes No

4. Do you take naps during the day? Yes No
 If yes, when, how many, and for how long?

5. Do you suffer from pain that interferes with your sleep? Yes No
 If so, please explain:

6. Have you been told that your snoring is (circle the appropriate response):

Light Moderate Loud Very Loud

7. Does it disturb your bed partner? Yes No



8. Has anyone told you that you stop breathing in your sleep? Yes No
9. Do you feel refreshed when you wake up in the morning? Yes No
10. Do you grind your teeth together while sleeping? Yes No
11. Have you ever walked in your sleep? Yes No
If so, at what age: _____
12. Do you have frequent nightmares? Yes No
13. Have you injured yourself or a bed partner "acting out" dreams? Yes No
If so, please explain: _____
14. Do you experience vivid dreams upon falling asleep or waking up? Yes No
15. Have you had spells where you feel that you are unable to speak or move when you are about to fall asleep or when you are awakening? Yes No

DURING THE DAY:

1. Have you experienced sudden muscle weakness (*that makes you fall or causes your knees to buckle*)?
When laughing? Yes No
When angry? Yes No
Other: _____
2. Do you feel tired during the day? Yes No
3. Are you sleepy or groggy during the day? Yes No
4. Does sleepiness interfere with your work? Yes No
5. Have you experienced sudden or uncontrollable sleep attacks? Yes No
6. Do you get sleepy while driving? Yes No



Name: _____ DOB: _____ Ht: _____ Wt: _____

Epworth Sleepiness Scale

Instructions: Please give the answer that most accurately describes the chances of you dozing off or falling asleep in the following situations. This refers to your usual way of life in recent times.

0 - Never; 1 - Slight; 2 - Moderate; 3 - High

Sitting and Reading	
Watching Television	
Sitting Inactive in a Seminar, Theater, or Meeting	
As a Passenger in a Car for One Hour	
Lying Down to Rest in the Afternoon	
While Having a Relaxed Conversation	
Sitting Quietly After Lunch	
In a Car While Stopping at a Traffic Signal	
Total Points	(Max/24)

Patient Signature

Date:

X _____

BDI

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____ Date: _____

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2, or 3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

- 1** 0 I do not feel sad.
1 I feel sad.
2 I am sad all of the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.
- 2** 0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things can't improve.
- 3** 0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life all I can see is a lot of failures.
3 I feel I am a complete failure as a person.
- 4** 0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things that way I use to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.
- 5** 0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.
- 6** 0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.
- 7** 0 I don't feel disappointed in myself anymore.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

- 8** 0 I don't feel I am any worse than anyone else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything that happens.
- 9** 0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.
- 10** 0 I don't cry anymore than usual.
1 I cry more now than I use to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.
- 11** 0 I am not more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.
- 12** 0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.
- 13** 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.
- 14** 0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe I look ugly.

- 15 0** I can work about as well as before.
1 It takes an extra effort to get started doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

- 16 0** I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1 to 2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

- 17 0** I don't get more tired than usual.
1 I get tired more easily than I use to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

- 18 0** My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

- 19 0** I haven't lost much weight, if any lately.
1 I have lost more than 5 pounds
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less.

(Circle One)

YES OR NO

- 20 0** I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

- 21 0** I have not noticed any recent change in my interest in sex.
1 I am less interest in sex than I use to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

_____ Subtotal Page 1

_____ Subtotal Page 2

_____ Total Scoring