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)

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

8. Do you consume caffeinated beverages? ☐ Yes ☐ No If yes, how many per day _____

9. Please check all major medical problems:

☐ Allergies	☐ Headaches/Migraines	☐ Depression/ Anxiety	☐ Diabetes	☐ Opioid Dependence
☐ Obesity	☐ High Blood Pressure	☐ TMJ/ Bruxism	☐ Impotence	☐ Heart Disease
☐ Ulcers	☐ Reflux/GERD	☐ Fainting/Black Outs	☐ Stroke	☐ Epilepsy
☐ Asthma	☐ Arthritis	☐ Incontinence	☐ Cancer	☐ Parkinson's
☐ COPD	☐ Thyroid Condition	☐ Kidney Trouble	☐ Bronchitis	☐ 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:

(EXAMPLE: 7:00 PM – 8:30AM)

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 your snoring 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 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 I can see 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 used 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 do not 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 do not cry any more than usual.
1 I cry more now than I used 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 do not 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 cannot make decisions at all anymore.

14
0 I do not 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 makes 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 do not get more tired than usual.
1 I get tired more easily than I used 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 have not 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