SLEEP QUESTIONNAIRE

**NAME: _____ AGE: _____ DOB: _____**

**DATE: _____ REQUESTING PHYSICIAN: _____**

**NOTE:** Please help us find out about you by filling out the "Patient" side of this form on pages 1-3. If you don't know the answer to one of the questions, ask your bed partner if he/she can answer it for you.

**PLEASE LEAVE "CLINICIAN" SIDE BLANK.**

| PATIENT | CLINICIAN |
|---|---|

**Why are you here to see a sleep specialist?** **CC**

**_____**

**_____**

**Do you snore:** **HPI**

**___ Yes ___ No ___ Don't Know**

**If yes, is it loud?**

**___ Yes ___ No ___ Don't Know**

**How long ago did it start? _____**

**Is it worsening?**

**___ Yes ___ No**

**In which position do you snore?**

**___ Back only ___ All positions**

**Is it worse on you back?**

**___ Yes ___ No**

**Do you snore if you fall asleep in a chair?**

**___ Yes ___ No**

**Does it disturb anyone?**

**___ Yes ___ No If yes, who? _____**

**Has anyone ever noticed if you stop breathing in your sleep?**

**___ Yes ___ No**

**Do you gasp or choke while you sleep?**

**___ Yes ___ No**

**Do you suffer from either of the following in the morning?**

**___ Dry mouth ___ Headache**

SLEEP QUESTIONNAIRE

**PATIENT** **CLINICIAN**

**Do you feel sleepy during the daytime?**

**___ Yes ___ No ___ Don't Know**

**How many days per week? _____**

**When did it start? _____**

**Is it worsening? ___ Yes ___ No ___ Don't Know**

**How likely are you to doze off or fall asleep in the following situations?**

**Please use the following scale:**

1. **Moderate chance of dozing**
2. **Slight chance of dozing**
3. **Moderate chance of dozing**
4. **High chance of dozing**

**___ Sitting and reading** **EPWORTH SCORE: _____**

**___ Watching television**

**___ Sitting inactive in a public place**

**___ While a passenger in a car without a break**

**___ Laying 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 in traffic for a few minutes**

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**Are you being treated now or have been treated for any illness?** **PERSONAL, FAMILY, SOCIAL HISTORY**

**Past Med Hx**

1. **_____**
2. **_____**
3. **_____**
4. **_____**
5. **_____**

**Have you ever had any operations? Any injuries?** **Past Surg Hx**

1. **_____**
2. **_____**
3. **_____**
4. **_____**
5. **_____**

**Check if any close family member has:** **Family Hx**

**___ Heart problems** **___ High Blood Pressure**

**___ Diabetes** **___ Cancer**

**___ Heartburn** **Other: _____**

SLEEP QUESTIONNAIRE

| PATIENT | CLINICIAN |
|---|---|
| **Marital Status S M W D** | **Social Hx** |
| **With whom do you live? _____** | |
| **What is your occupation? _____** | |
| **What are your leisure activities? _____** | |
| **What is your education level? _____** | |

| *Please circle any symptom you have, so we can find more about it:* | **REVIEW OF SYMPTOMS** |
|---|---|
| **Lack of energy; daytime sleepiness, trouble sleeping; Snoring; loss of appetite; weight changes; fevers** | **Constitutional** |
| **Eye problems, such as double or blurred vision; glaucoma; cataracts** | **HEENT** |
| **Hearing problems; buzzing or ringing in ears** | |
| **Allergies; hay fever** | |
| **Sinus problems** | |
| **Blood pressure or heart problems** | **Cardiac** |
| **Asthma; tuberculosis** | **Pulmonary** |
| **Stomach problems; heartburn; indigestion; change in bowel habits** | **Gastrointestinal** |
| **Urinary problems; frequency, infections; stones; bladder** | **Genito-Urinary** |
| **Men: Prostate problems; night-time urination** | |
| **Women: Abnormal menstrual periods; breast lumps; could you be pregnant; recent mammogram, pap smear or pelvic exam** | **Female Reproductive** |
| **Joint pains, swelling or redness; arthritis; back pain** | **Musculoskeletal** |
| **Muscle aches or tenderness; gout** | |
| **Rash, itching or other skin problems** | **Dermatologic** |
| **Paralysis (even temporary); numbness; loss of balance; Seizures; loss of memory; headaches; stroke;** | **Neurologic** |
| **Unusual thoughts; nervousness; crying or sadness; Suicide attempts; depression** | **Psychiatric** |
| **Thyroid disorder; diabetes; excess thirst or hunger; Frequent urination** | **Endocrinologic** |
| **Bleeding; easy bruising; risk factors for HIV; anemia; cancer** | **Hematologic** |
| **Others: _____** | |

**Personally reviewed by me. I agree with or have amended its findings.**

**_____**

**Physician Signature**

## PHYSICAL EXAMINATION

**BP _____ PULSE _____ SpO2 _____ RESP _____ T _____**

**GENERAL APPEARANCE _____**

***N=Normal A=Abnormal D=Deferred*** ***Description of Abnormal Findings***

1) ***NOSE:*** **Mucosa _____ Turbinates _____ Septum**

2) ***MOUTH:*** **Mucosa _____ Teeth _____Gums _____**
**Tongue _____ Pallate: Hard _____ Soft _____**
**Tonsils _____ Posterior Pharynx _____**

3) ***NECK:*** **Appearance _____ Symmetry _____**
**Tracheal Position _____ Crepitus _____**
**Thyroid _____ JVD _____**

4) ***RESPIRATORY:*** **Inspect _____ Symmetry _____**
**Percussion _____ Palpation _____**
**Auscultation _____ Effort _____**

5) ***HEART:*** **Apex _____ Heave _____ Thrill _____**
**Sounds _____ Murmur _____ Rub _____**

6) ***ABDOMEN:*** **Masses _____ Tenderness _____**
**Liver _____ Spleen _____ Bowel Sounds _____**

7) ***LYMPH:*** **Neck _____ Axilla _____ Groin _____**
**Other (Specify) _____**

8) ***MUSCULOSKELETAL/ NEUROLOGIC:*** **Gait _____**
**Station _____ Strength _____ Atrophy _____**
**Tone _____ Abnormal Movement _____**

9) ***EXTREMETIES:*** **Varicosities _____ Edema _____**
**Pulses _____ Temp _____ Tenderness _____**
**Digits _____ Nails _____**

10) ***SKIN:*** **Scars _____ Rashes _____**
**Describe _____**

11) ***NEUROPSYCH:*** **Oriented _____ Mood _____**

| New Patient | | Office Consult |
|---|---|---|
| 99201 | 1-5 Bullet Points | 99241 |
| 99202 | 6-11 Bullet Points | 99242 |
| 99203 | 12-17 Bullet Points | 99243 |
| 99204 | All Items with Gray Border and 1 | 99244 |
| 99205 | Item in each non-Gray Border | 99245 |

SLEEP QUESTIONNAIRE

## MEDICAL DECISION MAKING

**DATA REVIEWED:**

**Lab (Date)**

**Hemoglobin _____**

**Electrolytes _____**

**Other (Specify) _____**

**Pulmonary Function Test (Date) _____**

**Bronchoscopy (Date) _____**

**Other (List/Date) _____**

**X-Rays (Date)** **Physician Interpretation:**

**_____ Chest**

**_____ CT Chest**

**_____ MRI**

**_____ Other (List Type)**

**IMPRESSION:**

**PLAN:**

**F/U _____**

**___ PFT/Spirometry ___**
**___ V/Q Scan ___**
**___ Chest X-ray ___**
**___ Nocturnal Pulse Oximetry**
**___ Bronchoscopy**
**___ Lab**
**___ Pulm Risk Reduction**
**___ CPEX Level 1 ___ Level 2 ___**
**Other _____**

**_____**
**Physician Signature**