

# Methodist Medical Sleep Diagnostic Center

944 Oak Ridge Turnpike Oak Ridge, TN 37830 Phone (865) 835-3810 Fax (865) 835-3811

NAME: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

Who referred you? \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

Which physicians should our office send your sleep center records? \_\_\_\_\_

Describe your sleep problems: \_\_\_\_\_

\_\_\_\_\_

Duration? \_\_\_\_\_ Have you ever been to a sleep center before? Yes \_\_\_ No \_\_\_

If so, where and when? \_\_\_\_\_

What treatment was recommended? \_\_\_\_\_

**DROWSINESS / SLEEPINESS** Are you frequently fatigued or drowsy during the day? Yes \_\_\_ No \_\_\_  
Have you had any accidents or near traffic accidents due to sleepiness? Yes \_\_\_ No \_\_\_  
Have you had any accidents at work due to sleepiness? Yes \_\_\_ No \_\_\_  
Do you ever fight sleep while driving? Yes \_\_\_ No \_\_\_

**BODY POSITION** Do you spend most of the night sleeping on your back? Side? Stomach?

**SNORING / APNEA** Has anyone told you that you snore loudly? Yes \_\_\_ No \_\_\_  
Do you snore in all sleeping positions (on your back and sides)? Yes \_\_\_ No \_\_\_  
Do you snore almost continuously all night, every night? Yes \_\_\_ No \_\_\_  
Have you awakened with a dry mouth? Yes \_\_\_ No \_\_\_  
Has anyone told you that you quit breathing at night? Yes \_\_\_ No \_\_\_  
Have you ever awakened gasping for breath? Yes \_\_\_ No \_\_\_  
Do you have excessive sweating at night? Yes \_\_\_ No \_\_\_  
Do you ever wake at night with coughing, choking, or respiratory discomfort? Yes \_\_\_ No \_\_\_  
Do you have morning headaches? Yes \_\_\_ No \_\_\_ Morning sore throat? Yes \_\_\_ No \_\_\_

**REFLUX** Do you often wake with a sour taste/burning sensation in your chest/throat? Yes \_\_\_ No \_\_\_

**NARCOLEPSY** Do you have sudden episodes of sleepiness during the day? Yes \_\_\_ No \_\_\_  
Have you ever been unable to move when falling asleep and/or waking up? Yes \_\_\_ No \_\_\_  
Have you ever felt like your muscles were going limp when you are surprised, angry or sad? Yes \_\_\_ No \_\_\_  
Have you ever seen or heard things that aren't real (hallucinations) when you are going to or awakening from sleep? Yes \_\_\_ No \_\_\_

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**CHILDHOOD** Did you have childhood sleep problems of any type? Yes \_\_\_ No \_\_\_  
If yes, describe them. \_\_\_\_\_

**RLS/PLMS** Do your legs get tingling sensations/pain and you just have to move them? Yes \_\_\_ No \_\_\_  
Do you frequently kick or jerk your legs at night? Yes \_\_\_ No \_\_\_

**INSOMNIA** Do you have trouble going to sleep at your bedtime? Yes \_\_\_ No \_\_\_  
Do you have difficulty staying asleep? Yes \_\_\_ No \_\_\_  
Do you have pain that bothers you at night? Yes \_\_\_ No \_\_\_  
Thoughts race through my mind. This prevents me from falling asleep. Yes \_\_\_ No \_\_\_

**PARASOMNIAS** DO YOU (*THE PATIENT*) DO ANY OF THE FOLLOWING?  
Sleep walk? Yes \_\_\_ No \_\_\_ Wet the bed at night? Yes \_\_\_ No \_\_\_  
Have frequent nightmares? Yes \_\_\_ No \_\_\_ Talk in your sleep? Yes \_\_\_ No \_\_\_  
Ever wake up screaming? Yes \_\_\_ No \_\_\_ Falling out of bed? Yes \_\_\_ No \_\_\_  
Grind your teeth in your sleep or wake up with jaw pain? Yes \_\_\_ No \_\_\_

## WORK HISTORY:

**ARE YOU:** Employed? Yes \_\_\_ No \_\_\_ A homemaker? Yes \_\_\_ No \_\_\_ Retired? Yes \_\_\_ No \_\_\_  
What type of work do you do? \_\_\_\_\_

**ARE YOU:** A student? Yes \_\_\_ No \_\_\_ Highest level of education? \_\_\_\_\_  
Disabled? Yes \_\_\_ No \_\_\_ Due to what? \_\_\_\_\_

**WORK** When does your usual work shift start? \_\_\_\_\_ AM or PM

**SCHEDULE:** When does your usual work shift end? \_\_\_\_\_ AM or PM  
Hours worked per week? \_\_\_\_\_ Do you do shift work? Yes \_\_\_ No \_\_\_

## SLEEP SCHEDULE:

WEEKDAY WEEKEND WEEKDAY WEEKEND  
Time you go to bed \_\_\_\_\_ Time you get up \_\_\_\_\_

How long does it take you to fall asleep? \_\_\_\_\_ hours/minutes

How many times do you wake during the night? \_\_\_\_\_

How many hours of sleep do you need to feel rested? \_\_\_\_\_

Do you nap during the day? Yes \_\_\_ No \_\_\_

How many days/week do you nap? \_\_\_\_\_

How long will you sleep during your nap? \_\_\_\_\_

Have you ever taken any medications to help you fall asleep? Yes \_\_\_ No \_\_\_

If yes, what were the names of the medications and do you feel they helped? \_\_\_\_\_  
\_\_\_\_\_

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How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

- 0 - Would **never** doze  
2 - **Moderate** chance of dozing
- 1 - **Slight** chance of dozing  
3 - **High** chance of dozing
- Chance of dozing  
(write 0, 1, 2, or 3)

SITUATION

- Sitting and reading \_\_\_\_\_  
Watching television \_\_\_\_\_  
Sitting, inactive in a public place such as a theatre or a meeting \_\_\_\_\_  
As a passenger in a car for an hour without a break \_\_\_\_\_  
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 \_\_\_\_\_
- TOTAL SCORE: (Add All Responses) \_\_\_\_\_

OTHER ILLNESSES: Circle those that apply.

- |                         |                      |                 |                          |
|-------------------------|----------------------|-----------------|--------------------------|
| Diabetes                | High Blood Pressure  | Emphysema/COPD  | High Cholesterol         |
| Coronary Artery Disease | Irregular Heart Beat | Stroke          | Gastro-esophageal Reflux |
| Depression              | Anxiety              | Thyroid Disease | Kidney Disease           |
| Allergies               | Cancer               | Migraines       | Glaucoma                 |
- Other \_\_\_\_\_

SURGICAL HISTORY: Circle those that apply.

- |                              |                |               |                            |
|------------------------------|----------------|---------------|----------------------------|
| SINUS SURGERY                | Cardiac Bypass | Nasal Surgery | Hysterectomy/OO-phorectomy |
| Jaw Surgery / UPPP / Tonsils | Other _____    |               | Other _____                |
| Other _____                  | Other _____    |               | Other _____                |

DO YOU USE OXYGEN? Yes \_\_\_\_\_ No \_\_\_\_\_ \_\_\_\_\_ Liters/minute  
\_\_\_\_\_ Continuous \_\_\_\_\_ During Sleep \_\_\_\_\_ With Exertion \_\_\_\_\_ As Needed

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List Your Medications. Include over the counter medications, vitamins, and supplements.

NAME	SIZE (MG)	HOW YOU TAKE IT (Ex. 3 TIMES A DAY)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
Medication Allergies:		

**HEALTH HABITS:**

Do you smoke? Yes \_\_\_ No \_\_\_ If yes, how long? \_\_\_\_\_ How many packs/day? \_\_\_\_\_  
 Cigars/day? \_\_\_\_\_ If ex-smoker, how long did you smoke? \_\_\_\_\_ When did you quit? \_\_\_\_\_  
 Do you use smokeless tobacco? Yes \_\_\_ No \_\_\_ How much per day? \_\_\_\_\_

**ALCOHOL/DRUGS**

Do you ever drink alcohol? Yes \_\_\_ No \_\_\_

If yes, how much and what kind? \_\_\_\_\_

Have you ever had a problem with drinking too much alcohol? Yes \_\_\_ No \_\_\_

Use street drugs? Yes \_\_\_ No \_\_\_ Have a past history of substance abuse? Yes \_\_\_ No \_\_\_

**CAFFEINE** Do you drink coffee? Yes \_\_\_ No \_\_\_, Regular\_\_ or Decaffeinated\_\_, \_\_\_ cups/day

Do you drink soft drinks with caffeine Yes \_\_\_ No \_\_\_ How many/day? \_\_\_\_\_

Do you drink tea with caffeine Yes \_\_\_ No \_\_\_ How many cups/glasses/day? \_\_\_\_\_

**MEALS**

How many meals do you eat daily? \_\_\_\_\_

**EXERCISE**

Do you exercise regularly? Yes \_\_\_ No \_\_\_ Frequency \_\_\_ Minutes \_\_\_\_\_

Type of exercise: \_\_\_\_\_

**FAMILY HISTORY: Circle the Condition and then List Affected Family Members**

CONDITION	AFFECTED FAMILY MEMBER	CONDITION	AFFECTED FAMILY MEMBER
Diabetes	_____	Narcolepsy	_____
Heart Disease	_____	Daytime sleepiness	_____
High Blood Pressure	_____	Insomnia	_____
Stroke	_____	Depression/Anxiety	_____
Obesity	_____	Sleep Apnea	_____
Other (describe):	_____	Other (describe):	_____

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Circle all that apply within the last month.

**REVIEW OF SYSTEMS/SYMPTOMS**

<b>Eyes</b>	Blurry vision	Loss of Vision	Double vision	Dry Eyes	
<b>Ears, Nose &amp; Throat</b>	Hearing Loss	Ringing	Ear Pain	Sore Throat	Dry Mouth
<b>Heart</b>	Chest Pain	Heaviness	Rapid heartbeats		Ankle/let swelling
<b>Pulmonary</b>	Short of Breath	Wheezing	Cough	Coughing up blood	Phlegm
<b>Stomach &amp; GI Tract</b>	Dry Mouth	Trouble Swallowing	Stools Black as Tar	Constipation	Heart Burn
	Stomach Pain	Diarrhea	Bright blood in Stools	Nausea	Vomiting
<b>Genitourinary</b>	Urine with Cough	Incontinence	Trouble Emptying the Bladder	Blood in Urine	Frequent Urination
	Sexual Problems	Dribbling Urine		Burning	Menstrual Problems
<b>Muscle/Skeletal</b>	Back Pain	Neck Pain	Sore Muscles	Swollen Joints	
	Twitching Muscles	Arm or Leg Pain	Stiffness	Muscle Weakness	Cramps
<b>Skin</b>	Itching	Rash	Blisters	Peeling	Dry Skin
<b>Neurologic</b>	Weakness	Imbalance	Numbness/Tingling	In coordination	Dizziness
	Headache	Seizures	Tremor	Forgetfulness	Light Headedness
<b>Psychological</b>	Personality Change	Loss of Interest	Angry	Sad	Withdrawn
	Irritable	Depressed	Crying spells	Nervous	Suicidal Thoughts
<b>Endocrine</b>	Frequent Thirst	Always cold	Always Hot	Thyroid problems	Diabetes
<b>Hematologic</b>	Bruising	Bleeding Easily	Swollen Glands	Blood Clots	
<b>Allergy</b>	Burning Eyes	Runny Nose	Nasal Congestion		
<b>Constitutional</b>	Fatigue	Night Sweats			
<b>Weight</b>	Weight change in past 5 years: Yes/No		Gained ____#	Lost ____#	

Any other problems not listed?

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Who completed the questionnaire? \_\_\_\_\_

By yourself \_\_\_ or with help \_\_\_? If help, from whom? \_\_\_\_\_