

**Lexington Neurosciences Center
SLEEP QUESTIONNAIRE**

This questionnaire may seem lengthy, but it important that you fill it out as accurately as possible. Some of the questions may not pertain to you specifically, but please answer them as best you can. The questionnaire is a broad-based screening tool that will assist us and your physician to serve you better. It may be helpful to consult with your family members on some questions. All information contained in this questionnaire is held in strict confidence. **Please fill out all pages completely. This MUST be completed prior to seeing the physician.**

NAME _____ AGE _____ DATE: _____

Describe your sleep problem and how long you have had it _____

Have you ever been at a sleep center before? [] YES [] NO If yes, when? _____

Where? _____ Ever been on CPAP? [] YES [] NO

WORK SCHEDULE

When does your usual work shift start? _____ AM PM

When does your usual work shift end? _____ AM PM 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 go to sleep? _____ hrs/mins How often do you wake up at night? _____

How many hours do you sleep each night? _____ average (hrs) _____ minimum (hrs) _____ maximum (hrs)

Do you take naps? [] YES [] NO If yes, how many days per week? _____ On average, how long are the naps? _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life recently. Even if you have not done some of these things recently, try to answer how they would affect you. Use the following scale to choose the most appropriate number for each situation:

0 = would NEVER doze
1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

Situation

Situation	0	1	2	3
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
In a car, while stopped in traffic	0	1	2	3
Sitting inactive in a public place, such as a meeting or church	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you have not had alcohol)	0	1	2	3

SENSORY IMPAIRMENT (Check all that apply):

Vision	Hearing	Understands English	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	Primary Language:	
<input type="checkbox"/> Glasses	<input type="checkbox"/> Decreased	Able to read?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Contacts	<input type="checkbox"/> Hearing Aids	Able to write?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Blind	<input type="checkbox"/> Deaf	Do you need an interpreter?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SLEEP REVIEW OF SYSTEMS

DROWSINESS/SLEEPINESS

Are you frequently fatigued or drowsy during the day? Yes No

Have you had any accidents at work due to sleepiness? Yes No

Have you had any near traffic accidents due to sleepiness? Yes No

SNORING

Has anyone told you that you snore loudly? Yes No

Do you snore every night? Yes No Do you snore almost continuously? Yes No

Has anyone ever told you that you quit breathing or hold your breath at night? Yes No

Have you ever awakened gasping for breath? Yes No

Do you ever awaken at night with coughing, choking or respiratory discomfort? Yes No

Do you have a dry throat when you wake up in the morning? Yes No

Do you have trouble breathing through your nose at night? Yes No

Do you have trouble breathing through your nose during the day? Yes No

Do you have morning headaches? Yes No

Weight change last 5 years: Gained _____ lbs *or* Lost _____ lbs

REFLUX

Do you often awaken with a sour taste or burning sensation in your chest? Yes No

EXCESSIVE DAYTIME SOMNOLENCE

Do you have sudden episodes of sleepiness during the day? Yes No

Have you every had periods in which you felt paralyzed while going to sleep or waking up? Yes No

Have you ever had visual hallucinations or dream-like mental images when falling asleep? Yes No

Have you ever experienced sudden physical weakness during strong emotions? Yes No

(such as your mouth dropping open or legs going limp during laughter or anger)

CHILDHOOD SLEEP

Did you ever have childhood sleep problems of any type? Yes No

If yes, describe _____

RESTLESS LEGS SYNDROME/PERIODIC LIMB MOVEMENT DISORDER

Do you frequently kick and jerk your legs at night while trying to fall asleep? Yes No

Do you have discomfort in your lets while trying to fall asleep? Yes No

Does moving your legs give you relief of discomfort? Yes No

Do you have tingling or discomfort in your legs during the day? Yes No

Do you have discomfort in your legs when sitting for long periods? Yes No

INSOMNIA

Do you have difficulty initiating sleep at night? Yes No

Do you have difficulty staying asleep at night? Yes No

Do you have pain that bothers you at night? Yes No

PARASOMNIAS

Do you sleep walk? Yes No

Do you talk in your sleep? Yes No

Do you have frequent nightmares? Yes No

Do you grind your teeth in your sleep? Yes No

Has anyone ever told you that you act out your dreams? Yes No

Do you wet the bed at night? Yes No

Do you ever wake up screaming? Yes No

BED PARTNER'S QUESTIONNAIRE Ask someone familiar with your sleep to answer the following questions about you. Name of person completing section _____.

<i>Does the patient...</i>	
Stop breathing in his/her sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, how often do the pauses occur?	<input type="checkbox"/> Every night <input type="checkbox"/> Occasionally <input type="checkbox"/> Multiple times per night
Snore heavily?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Snore continuously?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Snore every night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Snore in the following positions?	<input type="checkbox"/> Back <input type="checkbox"/> Left side <input type="checkbox"/> Right side <input type="checkbox"/> All positions
Kick and jerk frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep walk or talk during sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No

OTHER ILLNESSES (Check all that you have been diagnosed with)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Irregular heartbeats | <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcers/reflux |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Chronic nasal congestion | <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines | <input type="checkbox"/> Cataracts |

SURGICAL HISTORY (Check all that apply)

- | | | | |
|--|--|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiac bypass | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Tonsils and/or adenoids | <input type="checkbox"/> Nose or sinuses | <input type="checkbox"/> Other: | |
| <input type="checkbox"/> Other: | | <input type="checkbox"/> Other: | |

TOBACCO Ever smoked? Yes No If yes, how long? _____ Packs/day _____
 Do you still smoke? Yes No If no, when did you quit? _____

ALCOHOL/DRUGS Do you drink alcohol? Yes No If yes, how often? _____ days per week
 How much on the average? _____

Have you ever had a problem with drinking too much alcohol? Yes No
 Do you currently use recreational (street) drugs? Yes No If so, what? _____

CAFFEINE

Do you drink: Regular caffeinated coffee? Yes No If yes, _____ cups/day
 Caffeinated soft drinks? Yes No If yes, _____ ounces/day
 Tea with caffeine Yes No If yes, _____ cups or glasses/day

MEALS/EXERCISE How many meals do you eat daily? _____ Do you exercise regularly? Yes No

FAMILY HISTORY (Circle the condition and list the affected family member(s), eg, mother, father, sister, etc)

<u>CONDITON</u>	<u>FAMILY MEMBER</u>	<u>CONDITON</u>	<u>FAMILY MEMBER</u>
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Narcolepsy	_____
<input type="checkbox"/> Heart disease	_____	<input type="checkbox"/> Daytime sleepiness	_____
<input type="checkbox"/> High blood pressure	_____	<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Anxiety	_____
<input type="checkbox"/> Obesity	_____	<input type="checkbox"/> Sleep Apnea	_____
<input type="checkbox"/> Other	_____		

REVIEW OF SYSTEMS*Check any symptoms that you have*

EYES	<input type="checkbox"/> blurry vision	<input type="checkbox"/> loss of vision	<input type="checkbox"/> double vision	<input type="checkbox"/> eye pain	<input type="checkbox"/> dry eyes
EAR, NOSE & THROAT	<input type="checkbox"/> hearing loss	<input type="checkbox"/> ringing	<input type="checkbox"/> ear pain	<input type="checkbox"/> sore throat	<input type="checkbox"/> dry mouth
HEART	<input type="checkbox"/> chest pain	<input type="checkbox"/> heaviness	<input type="checkbox"/> racing or pounding		
PULMONARY (LUNG)	<input type="checkbox"/> short of breath	<input type="checkbox"/> wheezing	<input type="checkbox"/> cough	<input type="checkbox"/> bloody cough	<input type="checkbox"/> phlegm
STOMACH/GI	<input type="checkbox"/> nausea	<input type="checkbox"/> vomiting	<input type="checkbox"/> black stools	<input type="checkbox"/> blood in stools	<input type="checkbox"/> trouble swallowing
GENITOURINARY	<input type="checkbox"/> urinerw/cough	<input type="checkbox"/> incontinence	<input type="checkbox"/> blood in urine	<input type="checkbox"/> frequent urination	
	<input type="checkbox"/> burning	<input type="checkbox"/> dribbling urine	<input type="checkbox"/> sexual problem	<input type="checkbox"/> trouble emptying the bladder	
MUSCLE/SKELETAL	<input type="checkbox"/> back pain	<input type="checkbox"/> neck pain	<input type="checkbox"/> sore muscles	<input type="checkbox"/> swollen joints	<input type="checkbox"/> cramps
	<input type="checkbox"/> arm/leg pain	<input type="checkbox"/> stiffness	<input type="checkbox"/> twitching muscles		
SKIN	<input type="checkbox"/> itching	<input type="checkbox"/> rash	<input type="checkbox"/> blisters	<input type="checkbox"/> peeling	<input type="checkbox"/> dry skin
NEUROLOGIC	<input type="checkbox"/> weakness	<input type="checkbox"/> numbness	<input type="checkbox"/> tingling	<input type="checkbox"/> dizziness	<input type="checkbox"/> incoordination
	<input type="checkbox"/> imbalance	<input type="checkbox"/> forgetfulness	<input type="checkbox"/> headache	<input type="checkbox"/> slurred speech	<input type="checkbox"/> tremor
	<input type="checkbox"/> jerking	<input type="checkbox"/> lightheadedness			
PSYCHOLOGICAL	<input type="checkbox"/> depressed	<input type="checkbox"/> irritable	<input type="checkbox"/> angry	<input type="checkbox"/> sad	<input type="checkbox"/> withdrawn
	<input type="checkbox"/> crying spells	<input type="checkbox"/> nervous	<input type="checkbox"/> personality change	<input type="checkbox"/> suicidal thoughts	
ENDOCRINE	<input type="checkbox"/> always cold	<input type="checkbox"/> always hot	<input type="checkbox"/> frequent thirst		
HEMATOLOGIC	<input type="checkbox"/> bruising	<input type="checkbox"/> swollen glands	<input type="checkbox"/> bleeding easily		
ALLERGY	<input type="checkbox"/> burning eyes	<input type="checkbox"/> runny nose	<input type="checkbox"/> chemical sensitivity		
CONSTITUTIONAL	<input type="checkbox"/> fatigue	<input type="checkbox"/> fever	<input type="checkbox"/> night sweats	<input type="checkbox"/> chills	<input type="checkbox"/> no appetite

MEDICATIONS/ALLERGIES**List any MEDICATION ALLERGIES** _____**List all medications (including vitamins and over-the-counter medications):**

NAME	DOSE	HOW YOU TAKE IT (ex: 3 times/day)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____

Thank you!

Lexington Neurosciences Center, PLLC

Patient Information (please complete all areas):

First Name _____ MI _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work (____) _____ Cell (____) _____

Date of Birth _____ SSN* _____

Sex: Male Female Marital Status: Single Married Divorced Widowed

Employer _____ Occupation _____

Emergency Contact (not living with you): _____

Phone No. _____ Alternate Phone No. _____

Relationship: Parent Child Sibling Friend Other: _____

Referring Physician: _____ Phone: _____

Family Physician: _____ Phone: _____

Primary Insurance: _____ Subscriber Name: _____

ID # _____ Group # _____ Policy Effective Date: _____

Subscriber's Date of Birth: _____ Subscriber's SSN* _____

Patient's Relationship to Subscriber: Self Spouse Child Other: _____

Secondary Insurance: _____ Subscriber Name: _____

ID # _____ Group # _____ Policy Effective Date: _____

Subscriber's Date of Birth: _____ Subscriber's SSN* _____

Patient's Relationship to Subscriber: Self Spouse Child Other: _____

Are you here due to an automobile or work-related injury? Yes No

If so, please complete the following:

Insurance Carrier: _____ Claim # _____

Billing Address: _____

Adjuster: _____ Phone: _____ Date of Injury: _____

Please read and sign the following consents:

Consent to Treatment

I authorize the physician(s) at Lexington Neurosciences Center, PLLC, and/or their delegates to examine and treat me according to accepted medical practices and within the scope of their abilities. I understand that it is my right to refuse any examination or treatment I do not wish to receive, however, if I choose to refuse recommended treatment, I will not hold the physicians, their delegates, or Lexington Neurosciences Center liable for any deleterious health effects or complications that may arise as a result of my refusal.

Signed: _____ Date: _____

Consent to Bill

I authorize the physicians at Lexington Neurosciences Center, PLLC, and/or their delegates to bill medical claims to my insurance carrier(s). I authorize any release of information necessary to expedite payment of insurance claims. I understand that I am responsible for all charges regardless of insurance coverage and I agree to remit payment for any charges not covered by my insurance company.

Signed: _____ Date: _____

Consent to Release/Obtain Information

I authorize the physicians at Lexington Neurosciences Center, PLLC, and/or their delegates to release information to and to obtain information from other medical practices, physicians, hospitals, laboratory and radiology providers, and any other medical entity in order to optimize or facilitate medical care provided to me. I understand that any release of information will be made under the provisions of the Health Information Portability and Accountability Act (HIPAA) and my privacy will be maintained to the greatest extent possible.

Signed: _____ Date: _____

Thank you!