BEL-RED SLEEP
DIAGNOSTIC CENTER

PATIENT QUESTIONNAIRE

Please make sure you bring this completed questionnaire with you to your sleep clinic appointment or you can email it back to info@bel-redsleepdiagnosticcenter.com. Our staff strives to understand your sleep symptoms, which may be complex in nature. Thank you for taking the time to complete this questionnaire.

First Name: _____ Last Name: _____Date of your Clinic Visit _____

Date of Birth: _____ Current Age_____ _____Male _____Female

Name of Physician who referred you to us_____ Name of Primary Care Physician: _____

Name(s) of other health care providers your information should be sent:_____

Please indicate the main symptoms for which you seek help from our sleep clinic:

____Snoring ____Sleepiness ____Breathing Pauses ____Restless Legs ____Insomnia ____Tiredness ____Other

Have you been evaluated in a sleep clinic in the past? ____YES ____NO

If "YES" please complete this section and provide for us any available previous written sleep study reports and evaluations. If "NO" Please go to "your breathing patterns during sleep"

Where and When?_____ Were you diagnosed with obstructive sleep apnea? ____YES ____NO

List any other diagnoses_____ Have you been treated with a CPAP machine? ____YES ____NO

Are you still using the CPAP? ____YES ____NO If not, why not _____

What is your Pressure Setting? _____ Your medical equipment company? _____

Have you had a surgery for sleep apnea? ____YES ____NO if yes, please list dates/location _____

Have you ever tried a dental device for snoring or sleep apnea? ___YES ___ NO

YOUR BREATHING PATTERNS DURING SLEEP

How loud is your snoring? ☐NO SNORING ☐ MILD ☐ MODERATE ☐ LOUD ☐ VERY LOUD

How long have you been told you snore? _____

Has your snoring worsened over time? ☐ YES ☐ NO

Have you ever awakened CHOKING or GASPING Sounds during sleep: ☐ YES ☐ NO

Has anyone ever told you that your breathing PAUSES during sleep: ☐ YES ☐ NO

Have you gained or lost weight in the last year? ☐ YES ☐ NO

If yes how much? _____

YOUR TYPICAL SLEEP SCHEDULE

What time do you **TYPICALLY** go to bed on: weekdays _____ /weekends _____

What time do you **TYPICALLY** awaken on weekdays: weekdays _____ /weekends _____

TYPICALLY about how many hours of sleep do you get on weekdays? _____

How long does it take you to fall asleep on: weekdays _____ /weekends _____

Do you **TYPICALLY** sleep throughout the night: weekdays _____ /weekends _____

If not how many times do you remember waking up on an average night: _____

Do you usually have trouble falling back asleep? ☐ YES ☐ NO

What **TYPICALLY** causes your awakenings? ☐ Snorting ☐ Choking/Gasping ☐ Bad Dreams ☐ Headaches

☐ Bed partner ☐ Leg Movements ☐ Leg Discomfort ☐ Urination ☐ Other_____

☐ Need to go to the Bathroom, How many times do you get up to use the bathroom a night?_____

Have you been feeling tired or sleepy? ☐ YES ☐ NO

Do you take naps? ☐ NO ☐ YES For how long?_____ How many days per week do you nap?_____

How many times per day? _____

Do you doze off while driving? ☐ YES ☐ NO

Have you ever been involved in any motor vehicle accident because of drowsiness? ☐ YES ☐ NO

Have you ever taken medications to improve your sleep? ☐ YES ☐ NO If Yes, What medications and were they effective? _____

How likely are you to doze off or fall asleep (not just feel tired) in the following situations?

Note: This refers to your usual way of life in recent times. If you have not done some of these things recently, try to determine the ways in which you might be in these situations.

	No Chance	**Slight Chance**	**Moderate Chance**	**High Chance**
Sitting and Reading	0	1	2	3
Watching TV	0	1	2	
Sitting inactive in a public place (Theater or Meeting)	0	1	2	3
Riding as a passenger in a car for an hour without a break	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 without alcohol	0	1	2	3
In a car while stopped for a few minutes in traffic	0	1	2	3
At the dinner table	0	1	2	3
While driving	0	1	2	3

How often does each item apply to you? (Check the number that applies to you)

	Never	Very Rare	Occasional (once Per Month)	Often (once per Week)	All the Time (2-4 times a week)
Restless Sleep	0	1	2	3	4
Have Nightmares	0	1	2	3	4
Wake up with a dry mouth	0	1	2	3	4
Wake up with a sore throat	0	1	2	3	4
Wake up with a morning headache	0	1	2	3	4
Wake up feeling that your heart is beating rapidly	0	1	2	3	4
Nasal or Sinus Congestion	0	1	2	3	4
Heartburn	0	1	2	3	4
Grind teeth when sleeping	0	1	2	3	4
Night sweats	0	1	2	3	4
Wake up feeling tired	0	1	2	3	4
Have difficulty waking up	0	1	2	3	4
Feel tired or sleepy during waking hours	0	1	2	3	4
Feel that you are not getting enough sleep	0	1	2	3	4
Feel down or sad	0	1	2	3	4
Difficulty staying focused	0	1	2	3	4
Difficulty with memory	0	1	2	3	4
Irritable most of the day	0	1	2	3	4
Sleep Walking	0	1	2	3	4
Sleep Talking	0	1	2	3	4
Physically acting out dreams while sleeping	0	1	2	3	4
Sudden jerking of the legs	0	1	2	3	4
Rhythmic movements of legs while sleeping	0	1	2	3	4
Restlessness or discomfort of the legs particularly at bedtime	0	1	2	3	4
Urges to move legs	0	1	2	3	4
Moving, stretching or walking make your legs feel better	0	1	2	3	4
Hallucinations when falling asleep or upon awakening	0	1	2	3	4
Momentary but complete paralysis when falling asleep or awakening	0	1	2	3	4
Brief episodes of muscle weakness brought on by strong emotion when awake	0	1	2	3	4

PAST MEDICAL HISTORY

Please check all that apply

CARDIAC		GASTROINTESTINAL		ENDOCRINE	
Heart Attack/Atherosclerosis	☐	Ulcers	☐	Diabetes	☐
Chest Pain/Angina	☐	Acid Reflux	☐	Hypothyroidism	☐
Atrial fibrillation	☐	Liver Disease	☐	Hyperthyroidism	☐
Palpitations	☐	Colitis	☐	Obesity	☐
High blood pressure	☐	Constipation	☐		
High Cholesterol	☐	Irritable bowel syndrome	☐		
Heart Failure	☐				
RESPIRATORY		**EAR/NOSE/THROAT**		**PSYCHIATRIC**	
Smoking	☐	Recurrent sinus infection	☐	Depression	☐
Asthma	☐	Allergies	☐	Anxiety Disorder	☐
Bronchitis	☐	Nasal Congestion	☐	Bipolar	☐
Emphysema/COPD	☐			Schizophrenia	☐
MUSCULOSKELETAL		**NEUROLOGIC**		**KIDNEY&BLADDER**	
Arthritis	☐	Stroke	☐	Urinary incontinence	☐
Low back pain	☐	Seizure disorder	☐	Prostate enlargement	☐
Neck pain	☐	Parkinson's disease	☐	Kidney disease	☐
Knee/hip pain	☐	Migraine headaches	☐	**OTHER:**	
Shoulder pain	☐	Head trauma	☐	Anemia (Any History)	☐
Fibromyalgia	☐	Spinal cord injury	☐	Cancer	☐
		Herniated disc	☐		

PAST SURGICAL HISTORY

Have you ever had surgery on your TONSILS, ADENOIDS, or NOSE: ☐ YES ☐ NO

MEDICATION ALLERGIES

Are you allergic to any medications? ☐ YES ☐ NO If yes, please list the name(s) of the medications……

MEDICATIONS

List all medications, including over the counter medications

Medication	Dosage	Times per day	Medication	Dosage	Times per day

YOUR FAMILY HISTORY

Does anyone in your immediate family (parents, sibling or children) have the following medical conditions.
Please indicate **F** for father, **M** for mother, **S** for sibling and **C** for the child.

Sleep Apnea ☐ Anxiety/depression ☐ Heart Attack ☐ Diabetes ☐ Stroke ☐ Snoring ☐ Bipolar ☐
High Cholesterol ☐ Seizure ☐ Narcolepsy ☐ Schizophrenia ☐ High Blood Pressure ☐ Heart failure
Insomnia ☐ Restless legs syndrome ☐

YOUR SOCIAL HISTORY

Marriage Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner
Children: ☐ None ☐ yes, but not living with ☐ yes living with me Ages _____
Work Status: ☐ Employed ☐ Retired ☐ Unemployed ☐ Disabled ☐ Student
Occupation (brief description): _____
What is the highest level of education you completed? _____

YOUR HABITS

How many caffeine-containing beverages do you consume on a typical day?
Coffee_____ Tea_____ Caffeinated soft drinks _____
At what time do you typically consume your LAST caffeinated drink _____
How often do you drink alcoholic beverages:_____
Your history of tobacco use: ☐ Never ☐ Current smoker Number of years smoking_____
Average # of packs/day _____ ☐ Former Smoker Quit date _____ Approx # of years smoked_____
Do you use illicit street drugs: ☐ YES ☐ NO If "Yes", please list: _____

_____

Please complete as accurately as possible: Current weight _____ Weight 5 years ago _____
Height _____ Neck size _____

Thank you again for taking the time to fill out this document. Doing so will make your clinic visit with your doctor more efficient. Feel free to write down other issues you might have in regards to your sleep. You may want to ask your bed partner for additional comments as well.
