PACIFIC SLEEP
PROGRAM

NEW PATIENT QUESTIONNAIRE

Name: _____ Date of Birth: _____/_____/_____

Height: _____ Weight: _____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations? Even if you have not done some of these things recently, give a general estimate for each situation.

0: **NEVER** doze
1: **SLIGHT** chance of dozing
2: **MODERATE** chance of dozing
3: **HIGH** chance of dozing

	Chance of dozing (0–3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g., a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when the circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Please answer the following questions to the best of your ability:

What is the main reason for your visit? _____

_____

Have you seen a physician before about your sleep or alertness problem? ☐ Yes ☐ No

Please list the physicians who should receive a copy of your sleep study results:

1.	2.

Have you had a previous sleep test? ☐ Yes ☐ No

If **Yes**, when and where: _____

Have you ever been diagnosed with any of the following sleep disorder(s)?

☐ Sleep apnea ☐ Restless leg syndrome ☐ Narcolepsy ☐ Other: _____

WORK

Occupation: _____ Do you work shift work? ☐ Yes ☐ No

If retired, previous occupation: _____

Typical work schedule: _____

Do you work with hazardous material or heavy machinery? ☐ Yes ☐ No

Do you have a commercial driver's license (truck, bus, etc.) or pilot's license? ☐ Yes ☐ No

SLEEP PATTERNS

Please complete the following questions about your sleep patterns as best you can. You may, if you wish, have a bed partner or family member complete this section with you.

If your sleep schedule is variable, please write a range (such as Bedtime 10 PM to 1 AM):

	Bedtime	Rise time	How long it takes you to fall asleep
Typical sleep schedule on week days/workdays	_____	_____	
Typical sleep schedule on weekend/days off	_____	_____	

How many times are you aware of awakening out of sleep, even if just momentarily? _____

Once you awaken during the night, how long does it typically take to fall back asleep?

☐ < 15 minutes ☐ 15–30 minutes ☐ 30–60 minutes ☐ 1+ hours

How many hours of sleep per night do you estimate that you usually get? _____ hours/night

Do you nap? ☐ Yes ☐ No If **Yes**, how frequently do you nap? _____

How long are your naps? _____ Do you feel more refreshed after your naps? ☐ Yes ☐ No

Do you consider yourself a: ☐ Morning person/"Early Bird" ☐ Evening person/"Night Owl" ☐ Neither

SLEEP PATTERNS (CONT.)

Please answer the following questions by placing an "X" under the option that best fits.

	Seldom/ never	Sometimes	Usually/ always
Do you feel like your sleep is refreshing?			
Is your sleep area cool, dark, and quiet?			
Are you bothered by outside lights or noises when you sleep?			
Do you watch TV or use electronic devices (computer, tablets, etc.) before bed?			
Do you lie awake at night feeling worried or depressed or with your mind "racing"?			
Do pain issues disturb your sleep?			

Do you use pills (prescription or over-the-counter) or other substances to help you sleep? ☐ Yes ☐ No

If **Yes**, please describe: _____

Do you use alcohol or other controlled substances to help you sleep? ☐ Yes ☐ No

If **Yes**, please describe: _____

What body positions do you sleep in? Check all that apply.

☐ On my back ☐ On my stomach ☐ With the head of the bed elevated

☐ In a recliner ☐ On my sides

Do you have a bed partner? ☐ Yes ☐ No

If **Yes**, please answer the following questions by placing an "X" under the option that best fits:

	Seldom/ never	Sometimes	Usually/ always
Does your bed partner "elbow" you to change positions during sleep?			
Does your bed partner use earplugs or leave the room due to your snoring?			

Please answer the following questions by placing an "X" under the option that best fits.

	Seldom/ never	Sometimes	Usually/ always
Have you been told (by anyone) that you snore?			
Have you been told that you snore loudly and bother others?			
Have you been told that you appear to stop breathing during sleep?			
Are you aware of choking or gasping awake during sleep?			
Do you awaken with your mouth or throat dry and irritated?			
Do you have bothersome nasal congestion during sleep?			

SLEEP PATTERNS (CONT.)

Do you awaken from sleep for urination? ☐ Yes ☐ No If **Yes**, how often? _____ times/night

Please answer the following questions by placing an "X" under the option that best fits.

	Seldom/ never	Sometimes	Usually/ always
Do you awaken from sleep for heartburn (reflux or GERD)?			
Do you awaken from sleep with night sweats?			
Do you awaken from sleep with a headache?			
Do you awaken from sleep with chest pain or your heart racing?			
Are you aware of grinding your teeth during sleep, or has a dentist told you that you do this?			

If **Yes**, do you wear a night guard? ☐ Yes ☐ No

Do you have any history of orthodontic treatment (such as braces)? ☐ Yes ☐ No

Have you any weight changes over the past 5 years?

☐ No ☐ Yes _____ lbs gain ☐ Yes _____ lbs loss

	Seldom/ never	Sometimes	Usually/ always
Are you drowsy or sleepy during your regular awake hours?			
Do you have problems with memory or concentration?			
Lately, have you felt more depressed or more anxious?			
Do you use coffee, caffeine drinks, or stimulants to stay alert?			
Do you feel sleepy when driving?			

Have you had any driving accidents or "close calls" due to fatigue? ☐ Yes ☐ No

Have you been injured because of fatigue or sleepiness? ☐ Yes ☐ No

SLEEP PATTERNS (CONT.)

	Seldom/ never	Sometimes	Usually/ always
Do you experience persistent, uncomfortable feelings in your legs and/or arms while sitting or lying down?			
Do unpleasant feelings in your legs make it difficult for you to get to sleep or awaken you at night?			
Do you twitch or make sudden jerking movements during sleep?			
Do you awaken yourself or your bed partner by kicking during sleep?			

Have you been told, as an adult, that you sleepwalk or have awoken with periods of confusion or disorientation during the night? ☐ Yes ☐ No

Do you act out dreams (with vigorous arm or leg movements) during sleep? ☐ Yes ☐ No

Do you have frequent or repetitive frightening dreams or nightmares? ☐ Yes ☐ No

Have you wet the bed during sleep as an adult? ☐ Yes ☐ No

Do you have a history of seizures during sleep? ☐ Yes ☐ No

Have you heard voices or seen visions as you drift into or awaken from sleep? ☐ Yes ☐ No

Do you awaken from sleep unable to move or speak (as if you are paralyzed), yet you feel like you are awake? ☐ Yes ☐ No

Do you have attacks of physical weakness (actual loss of muscle control) when laughing or crying, or during other emotional situations? ☐ Yes ☐ No

MEDICAL HISTORY

Please check all that apply to you. ☐ None

☐ Atrial fibrillation	☐ Seizures	☐ Chronic sinus issues	☐ Fibromyalgia
☐ Cardiac arrhythmia	☐ Diabetes mellitus	☐ Benign prostate enlargement	☐ Chronic pain
☐ Coronary artery disease	☐ COPD/Emphysema	☐ Anemia	☐ TMJ (jaw) problems
☐ High blood pressure	☐ On supplemental oxygen therapy	☐ Kidney stones	☐ Glaucoma
☐ History of heart attack	☐ High cholesterol	☐ Erectile dysfunction	☐ History of alcohol abuse
☐ Congestive heart failure	☐ Post-traumatic stress disorder (PTSD)	☐ Acid reflux or heartburn	☐ History of drug abuse
☐ History of stroke	☐ Attention deficit disorder (ADD)	☐ Irritable bowel syndrome	☐ History of tobacco use
☐ Migraine disorder	☐ Anxiety disorder	☐ Polycystic ovary disease (PCOS)	☐ Other: Please list in the spaces below
☐ Headache disorder	☐ Depression	☐ Hypothyroidism	1.
☐ History of head injury	☐ Bipolar disorder	☐ Hyperthyroidism	2.
☐ History of concussion	☐ Allergies	☐ Goiter	3.
☐ Childhood/Teen head injury	☐ Asthma		4.

SURGICAL HISTORY

Please check all that apply to you. ☐ No previous surgeries

☐ Nasal or sinus surgery	☐ Spine surgery	☐ Cardiac stent	
☐ Palate surgery	☐ Tracheostomy	☐ Cardiac bypass	☐ Other: Please list in the spaces below
☐ Nasal septum surgery	☐ Thyroid surgery	☐ Hysterectomy	1.
☐ Tonsillectomy	☐ Weight loss surgery	☐ Cosmetic surgery	2.
☐ Adenoidectomy	☐ Brain surgery	☐ Wisdom teeth removal	3.
☐ Jaw surgery			4.

SOCIAL HISTORY

Do you drink caffeinated beverages? ☐ Yes ☐ No

If **Yes**, how many servings? _____ servings per ☐ day ☐ week

Do you drink caffeine within 6 hours of going to bed? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No

___Cigarettes ___Vape ___Cigars ___Pipe ____Chew

If **Yes**, how many packs/cans per day and for how long? _____ packs/day for _____ years

If **No**, have you ever smoked? ☐ Yes ☐ No

If **Yes**, when did you quit? ___/___/____

(if you can't remember the exact date, give your best approximation)

Do you drink alcohol?

If **Yes**, how many alcoholic drinks do you have during the week?

_____ glasses of wine _____ cans of beer _____ shots of liquor

Do you use recreational drugs? ☐ Yes ☐ No

If **Yes**, which types and how often per week? _____

Do you exercise? ☐ Yes ☐ No

If **Yes**, what type of exercise and how frequently? _____

FAMILY HISTORY

☐ Family history unknown ☐ No family history of sleep or cardiovascular disorders

If you did not check either box, please complete the table below.

Relationship	Sleep Apnea	Suspected Sleep Apnea	Insomnia	Restless Leg Syndrome	Narcolepsy	High Blood Pressure	Heart Disease	Stroke
Mother								
Father								
Sister								
Brother								
Daughter								
Son								
Other								

MEDICATIONS AND ALLERGIES

Name of and location of preferred pharmacy: _____

_____

Please list all of your current medications and dosages, including non-prescription medications.

Medication	Dosage	Medication	Dosage
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5		10.	

Do you have allergies to any medications or substances (e.g., latex)? ☐ Yes ☐ No

If **Yes**, please list each medication or substance you are allergic to and explain how you react to it below:

Medication/Substance	Reaction	Medication/Substance	Reaction
1.		3.	
2.		4.	