Please use black ink only!

Name: _____ SS# _____

Sex: ☐ M ☐ F Race: _____ Marital Status: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone #: ( )_____

Cell phone #: ( )_____ E-mail Address: _____

Employer's Name: _____

Employer's Address: _____ City: _____

State: _____ Zip: _____ Work Phone #: ( )_____

Referring Doctor: _____ Doctor's Address: _____

Phone Number: _____ _____

Fax Number: _____ _____

Primary Care Doctor: _____ Primary Care Doctor's phone number: _____

****PLEASE PROVIDE COPIES OF ALL INSURANCE CARDS****

Primary Insurance:

Company Name: _____

Guarantor/Subscriber Name: _____ Date Of Birth: _____

Relationship to Patient: _____ SSN: _____

Policy #: _____ Group #: _____

Policyholder's Employer (if policyholder is other than patient): _____

Secondary Insurance:

Company Name: _____

Guarantor/Subscriber Name: _____ Date Of Birth: _____

Relationship to Patient: _____ SSN: _____

Policy #: _____ Group #: _____

Policyholder's Employer (if policyholder is other than patient): _____

WHO DO WE CONTACT IN CASE OF AN EMERGENCY?

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State/Zip: _____

Day Phone # ( )_____ Evening Phone # ( )_____

PLEASE PROVIDE ALL THE INFORMATION REQUESTED ON THIS FORM. THIS HELPS US TO REGISTER YOU CORRECTLY AND EFFICIENTLY INTO OUR SYSTEM.

THANK YOU. WE LOOK FORWARD TO SERVING YOU!

CAPE FEAR VALLEY SLEEP CENTER

AN1530

PATIENT ID LABEL

Sleep Center Questionnaire I AN1530

SLEEP QUESTIONNAIRE I

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE AND BRING TO YOUR SCHEDULED APPOINTMENT.

Your Name: _____ Your Occupation: _____

1. What sleep related problems are you having? _____

_____

_____

_____

2. Please list all medical illnesses: _____

_____

_____

_____

3. Please bring a list of your current medications or use the enclosed form.

4. Have you ever used medications to help you sleep? ☐ Yes ☐ No

If YES, what? _____ when? _____ For how long? _____ Dose? _____

5. What is your regular bedtime? _____ Usual waking time? _____

Insomnia

6. Do you travel frequently across time zones? ☐ Yes ☐ No
7. How many hours per week do you work? ☐ Yes ☐ No
8. Does your work involve rotating shifts? ☐ Yes ☐ No
9. Do you have difficulty falling asleep? ☐ Yes ☐ No
10. How long does it take you to fall asleep, usually? _____
11. Do you awaken during the night? ☐ Yes ☐ No

If YES, how many times and for how long? _____

12. What awakens you and how long does it take you to fall back to sleep? _____

_____

13. Do you feel refreshed upon waking? ☐ Yes ☐ No

EDS

14. Do you feel excessively sleepy during the day? ☐ Yes ☐ No
15. Do you have sleepiness during the day that you cannot resist (e.g. falling asleep while driving, eating, at work)? ☐ Yes ☐ No

Narcolepsy

16. Do you or have you ever lost muscle tone in part or all of your body when suddenly surprised, angered, frightened, or amused (muscle tone loss would be knees buckling, jaw going slack, falling, etc. without any loss of consciousness or change in consciousness?) ☐ Yes ☐ No

17. When falling asleep or awakening, do you ever feel paralyzed or unable to move at all? ☐ Yes ☐ No

18. When attempting to fall asleep, do you ever experience vivid dream-like episodes? (hallucinations?) ☐ Yes ☐ No

RLS

19. In the evenings or at bedtime when trying to fall asleep, do you experience restless legs, leg discomfort when trying to keep legs still, or need to move your legs frequently to get comfortable? ☐ Yes ☐ No

If YES, does movement of your legs provide temporary (seconds to a minute) relief from leg discomfort before you have to move them again to get comfortable? ☐ Yes ☐ No

PS

20. Do you walk in your sleep? ☐ Yes ☐ No

If YES, do you ever exhibit complex behaviors when sleep walking, such as wandering out of the room or house, eating, performing tasks or automatic behaviors you do not remember doing the next morning? Explain: _____

_____

21. Do you ever awaken from sleep screaming, violent and confused, or hit, slap, kick things or bed partners while asleep? ☐ Yes ☐ No

22. According to your bed partner, do you ever seem to act out a dream or show violent behavior while asleep which you do not remember? ☐ Yes ☐ No

23. Do you grind your teeth while you sleep? ☐ Yes ☐ No

24. Have you ever wet your bed as an adult? ☐ Yes ☐ No

SA

25. Do you snore? ☐ Yes ☐ No

If YES, in which sleeping positions and how long? _____

_____

26. Do you ever stop breathing while you sleep? ☐ Yes ☐ No

If YES, in which sleeping positions and how long? _____

_____

27. Do you ever awaken during the night gasping for breath or with a snore you hear yourself? ☐ Yes ☐ No

28. Do you drink alcoholic beverages? ☐ Yes ☐ No

    If YES, how much and when? _____

29. How many alcoholic beverages do you have within 2 hours of bedtime? _____

30. Do you drink caffeine? ☐ Yes ☐ No

    If YES, how many cups of caffeinated beverages do you have in an average day? _____

31. Do you smoke? ☐ Yes ☐ No

    If YES, how much and for how long? _____ pack/day for _____ years

32. Which, if any, of the following substances have you used in the past month?

    ☐ None ☐ Cocaine ☐ Marijuana ☐ Amphetamines ☐ Heroin ☐ Other _____

33. Has anyone in your family been diagnosed with narcolepsy? ☐ Yes ☐ No

    If YES, what relation are they to you? _____

34. Is there anyone in your family that has sleep apnea or severe snoring? ☐ Yes ☐ No

35. Do you have any family members who sleepwalk or have other unusual behaviors during sleep? ☐ Yes ☐ No

36. Has your neck collar size and weight changed in the last year? ☐ Yes ☐ No

    In the past 10 years? ☐ Yes ☐ No

Is there anything else you wish to add that you feel will help the clinicians better understand your sleep? _____

CHIEF COMPLAINTS QUESTIONNAIRE

Please select 3 sleep complaints from the list below that are the most bothersome for you or which resulted in this sleep evaluation. Please rank in the order of 1 being the most bothersome complaint, 2 being the next, and 3 being the least bothersome.

Complaints:

_____ Can't get up or wake up in the morning

_____ Can't go to sleep

_____ Can't stay asleep once I go to sleep

_____ People say I snore loudly

_____ I am really sleepy during the day when I should not be

_____ Nightmares or bad dreams

_____ Uncomfortable feelings in arms or legs when trying to fall asleep

_____ People say I stop breathing when I sleep

_____ I do unusual things in my sleep (please list) _____

_____ My muscles feel weak after an emotional event

_____ I work rotating shifts

_____ I wake up feeling confused/headache/dry mouth

_____ Other

Please tell us what you have done in the past to manage these symptoms (i.e. taking naps, using sleeping pills, etc.)

_____

_____

_____

_____

_____

_____

Please place an X in the column that answers the question best.	Never 1	2	Sometimes 3	4	Often 5
EDS					
1. Do you fall asleep while watching TV or at the movies?					
2. Do you fall asleep reading newspapers, books, or magazines?					
3. Do you get extremely sleepy while driving or fall asleep at stoplights?					
4. Do you fall asleep while talking with someone in person or over the telephone?					
5. Have you had an automobile accident or driven off the road because of sleepiness?					
6. Do you now, or have you in the past, fallen asleep while at work?					
7. Do you fall asleep whenever you are inactive or bored?					
SA					
8. Do you snore or has someone told you that you snore loudly?					
9. Has your bed partner ever told you that you stop breathing during sleep?					
10. Has your bed partner awakened you for fear that you were not breathing?					
11. Do you ever wake up in the morning with headaches?					
12. Are you having trouble having sex recently?					
13. Do your ankles swell?					
PS					
14. Do you ever “sleep walk?”					
15. Have you ever performed simple tasks during the day that you don’t remember later?					
16. Do you have vivid dreams as you are going to sleep or waking up?					
17. Do you “wet” the bed?					
18. Do you “talk” in your sleep?					
19. Have you ever struck your bed partner or injured yourself during sleep?					
20. Do you think you have seizures?					
RLS					
21. Any uncomfortable feelings in leg/arms that improve with movement?					
Cataplexy					
22. Do you “go limp” after a good joke or something very upsetting?					

_____ _____/_____

Form Completed by Date Time

_____

Relationship