UC San Diego Health

SLEEP PATIENT QUESTIONNAIRE (INTAKE FORM)

Date: __________ Patient Name: _____________________________ DOB ____________MRN________________

Primary Care Physician: ______________________________ Referring Physician: _________________________

What is your profession? ________________________ What is your work schedule? ________________________

Chief Complaint (main reason for your visit):

____

____

____

Have you ever been diagnosed with a sleep disorder? ____

If yes, please specify: ____

Are you currently on any treatment for your sleeping disorder? ____

If yes, please specify: ____

Have you ever taken any Sleep Medication? ____

If yes, please specify: ____

Sleep Review

Bedtime _______am/pm

Wake time ______am/pm

Number of awakenings_______/night

Average Number of Sleep Hours per Night____

Please Answer Yes/No to each of the following Questions:

Snoring		Sleep/Wake problems related to shiftwork	
Witnessed Episodes of pauses of breathing		Sleepwalking	
Awakening with racing heart or panic feeling		Eating at night or during sleep	
Awakening with profuse sweating		Nightmares	
Trouble falling asleep		Acting out dreams	
Trouble staying asleep		Urinating more than once per night	
Sleepiness/Fatigue		Leg sensations that interfere with sleep	
Napping several times per week		Circadian disturbance, i.e. problematic sleep/wake schedule	
Drowsy Driving			

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Review of Systems

Have you had any of the following symptoms to a significant degree since you last saw a physician?
Please answer yes/no: (Y/N)

Symptom	Y/N	Symptom	Y/N
Weight Loss		Abdominal Pain	
Weight Gain		Nausea/vomiting	
Fever		Swelling in the extremities	
Night sweats		Lumps	
Chills		Rash	
Head Trauma		Sudden Weakness	
Vision Change		Headache	
Allergy Symptoms (runny nose, sneezing)		Seizure	
Sore Throat		Loss of Consciousness	
Shortness of breath		Severe Depression	
Chronic cough		Anxiety	
Wheezing		Mania	
Chest Pain		Pain	
Rapid or irregular heart beat			

Medical History
Check all that apply:

- ☐ Hypertension
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Weight Problem
- ☐ Diabetes
- ☐ Cardiac Arrhythmia
- ☐ Kidney Disease
- ☐ Hypothyroidism
- ☐ High Cholesterol
- ☐ Liver Disease
- ☐ Hyperthyroidism
- ☐ Cancer
- ☐ COPD (Emphysema or Chronic Bronchitis)
- ☐ Anemia
- ☐ Asthma
- ☐ Pulmonary Hypertension
- ☐ Blood Clots
- ☐ Seizures
- ☐ GERD (Heartburn)
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Anxiety
- ☐ Chronic Fatigue Syndrome
- ☐ Chronic pain
- ☐ Chemical dependency
- ☐ Chronic nasal congestion
- ☐ Sleep Apnea
- ☐ Narcolepsy
- ☐ Insomnia
- ☐ Restless Legs Syndrome
- ☐ Other ____

Have you had a tonsillectomy? Yes No

If yes, what year _____ what age? ______

Please indicate your other head and neck surgical history ________________________

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Epworth Sleepiness Scale
On a scale of 0-3, how likely are you to fall asleep or start to nod off in the following situations in contrast to just feeling tired?

0- No chance of dozing
1- Slight chance of dozing
2- Moderate chance of dozing
3- Severe chance of dozing

Sitting and reading ____
Watching TV ____
Sitting, inactive in a public place ____
As a passenger in a car for an hour without a break ____
Lying down to rest in the afternoon ____
Sitting and talking to someone ____
Sitting quietly after lunch without alcohol ____
In a car while stopped for a few minutes in traffic ____

Total ____

Family History of Sleep Disorders

- ☐ Sleep Apnea
- ☐ Insomnia
- ☐ Narcolepsy
- ☐ Restless Leg Syndrome
- ☐ Other sleep disorder ____________________________ ____________________________

Are you interested in participating in clinical trials? **YES** **NO**

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New patients to UCSD, Please fill out information below

Social History

Are you a smoker?	Never	Former	Current			
Do you drink alcohol?	Never	Quit	Occasionally	Weekly	Daily	_____Glasses
Do you drink caffeine?	Never	Quit	Occasionally	Weekly	Daily	______Cups
Do you exercise?	No	Yes				

If yes, how many times per week? _______________________

How long is each session? _______________________

Do you have pets? No Yes

If yes, what are they? _______________ _________________ ________________ ______________

Family History

Family history of medical conditions (Please specify **ONLY** Mother (M), Father (F), Siblings(S/B) or Children (C)). Please check those that apply and list which family member:

☐ Diabetes _______________ ☐ Hypertension ______________ ☐ Narcolepsy ________________

☐ Stroke __________________ ☐ High Cholesterol_____________ ☐ Insomnia __________________

☐ Cancer _________________ ☐ RLS _____________________ ☐ Heart Disease __________

☐ Sleep Apnea _____________ ☐ Heart Attack _____________ ☐ Cardiac Arrhythmia __________

☐ Sleep Disorders_________________________________

Allergies

List any allergies to medications:

___________________________ ____________________________ _________________________

___________________________ ____________________________ _________________________

Medication

Please provide a list of your most recent medications in the space below or attach a list. Please include Vitamins/

Minerals, Dietary Supplements and over the counter medications.

___________________________ __________________________ ____________________________

___________________________ ____________________________ ____________________________