



**New Patient History Questionnaire**  
Please complete this form at home rev 01Sep09

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Weight: Now \_\_\_\_\_ One year ago \_\_\_\_\_ Maximum \_\_\_\_\_

Reason for visit today: \_\_\_\_\_

**FAMILY HISTORY:**

How many brothers? \_\_\_\_\_ Sisters? \_\_\_\_\_ Father Mother Brother(s) Sister(s)

	Father	Mother	Brother(s)	Sister(s)
Age (if living; or at death)				
Health (good or bad)				
Sleep walking				
Snoring				
Sleep Apnea				
Hypertension				
Diabetes Mellitus				
Coronary Artery Disease				
CVA - Stroke				
Cause of death if deceased				
Other inherited condition (explain)				

**REVIEW OF SYSTEMS: If yes, what year did the problem start?**

	<i>Start Year</i>			<i>Start Year</i>	
Glaucoma	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Diabetes	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Rheumatic fever, heart disease	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Anemia: Jaundice	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Arthritis: Rheumatism	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Epilepsy, Seizures	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Bone or joint disease	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Liver disease	<input type="checkbox"/> no <input type="checkbox"/> yes _____
High blood pressure	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Asthma	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Heart disease	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Broken bones	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Atrial fibrillation	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Head injury	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Cardiac pacemaker/defibrillator	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Skin rashes	<input type="checkbox"/> no <input type="checkbox"/> yes _____
High cholesterol	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Cancer	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Eye disease or injury	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Chest Pain	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Vision loss temporary-permanent	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Shortness of breath	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Ear disease or injury	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Palpitations, heart flutter	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Fainting spell	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Kidney disease	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Numbness: part of body _____	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Trouble urinating	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Headaches, frequent or severe	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Stomach ulcer	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Change in appetite	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Liver disease	<input type="checkbox"/> no <input type="checkbox"/> yes _____

**PERSONAL HISTORY:**

Married  No  Yes # years \_\_\_\_\_ Children  No  Yes # \_\_\_\_\_ Profession: \_\_\_\_\_

**On the average, how many of the following do you use each day?**

Natural coffee, caffeinated..... \_\_\_\_\_ cups      Chocolate..... \_\_\_\_\_ pieces daily  
 Tea, caffeinated..... \_\_\_\_\_ cups      Alcohol beverages..... \_\_\_\_\_ daily or weekly  
 Colas with caffeine..... \_\_\_\_\_      Tobacco products..... \_\_\_\_\_

**PAST MEDICAL HISTORY/HOSPITALIZATIONS: Any Past Surgeries: If yes, year surgery performed**

Tonsils	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Appendix	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____
Hysterectomy	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Gallbladder	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____
Disc	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Pinched nerve	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____
Weight loss surgery	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____	Other Surgeries/Hospitalizations	<input type="checkbox"/> no	<input type="checkbox"/> yes	_____

**YOUR ALLERGIES: Write any allergies:**

Medication	What happened: rash, swelling, other reaction?	Year occurred

**MEDICATIONS You currently take:**

Medication Name	Amt per pill (mg)	Frequency	Reason you take the medication	Year started

**IF YOU HAVE HAD ANY OF THE TESTS BELOW, PLEASE DESCRIBE THE RESULTS**

Test	Year	Result
Chest X-Ray		
EKG (cardiogram)		
EEG (brainwave)		
Polysomnogram (sleep test)		
Have you ever had abnormal heart rhythm? If yes, please give details:		

**Describe any other important information here:**

**FOR WOMEN ONLY:**

Do you have regular menstrual periods?  yes  no      Problems associated with periods?  yes  no

**ARLINGTON SLEEP MEDICINE, Ltd.**  
**New Patient Sleep Questionnaire**

Please answer all the questions as accurately as possible, since your answers will help diagnose and treat your complaints. Please answer the following questions with your sleeping partner as completely and accurately as you can. Bring this questionnaire with you on your first visit.

Please ask your sleeping partner to rate your sleep when requested below.

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What year was your last physical exam? \_\_\_\_\_ Physician's name: \_\_\_\_\_  
Doctor's Address: \_\_\_\_\_  
Doctor's phone number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  
Brief results of exam: \_\_\_\_\_

Do you exercise adequately?.....Yes No How? \_\_\_\_\_

**GENERAL SLEEP INFORMATION:**

1. How long have you had a sleep problem? \_\_\_\_\_wks \_\_\_\_\_mos \_\_\_\_\_yrs
2. How many nights each week do you have a sleep problem? \_\_\_\_\_ nights
3. What time do you usually go to bed? \_\_\_\_\_am \_\_\_\_\_pm
4. What time do you usually leave bed to start your morning routine? \_\_\_\_\_am \_\_\_\_\_pm
5. Are you usually refreshed when you get out of bed in the morning? Yes / No
6. How many hours do you sleep on an average night? \_\_\_\_\_hours
7. How many times do you wake up during an average night? \_\_\_\_\_times
8. How long altogether are you awake after you first fall asleep? \_\_\_\_\_minutes
9. On average, how many days each week do you nap? \_\_\_\_\_times per week  
What time? \_\_\_\_\_ Average length of nap? \_\_\_\_\_

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**AFTER DECIDING TO GO TO SLEEP AT NIGHT:**

- 10.-Do you have difficulty getting to sleep? yes no
- 11.-How long does it usually take you to fall asleep? \_\_\_\_\_minutes
- 12.-Do you experience pain or physical discomfort? yes no
- 13.-Do you feel unable to relax? Do your thoughts race? yes no
- 14.-Do you have odd sensations or restlessness in your legs as you fall asleep? yes no
- 15.-Do you have twitches or movements in your legs or arms as you fall asleep? yes no
16. Check which of the following techniques you use to help fall asleep:  
( ) medication ( ) baths, hot tubs, etc  
( ) biofeedback ( ) exercise  
( ) hypnosis (tapes, etc) ( ) special diets, foods, drinks or vitamins  
( ) relaxation techniques ( ) mental imagery (counting sheep, etc)

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**AFTER FALLING ASLEEP:**

- 17.-Do you have any unusual sleep behavior? .....yes no  
Sleeping partner's response. ....yes no  
If yes, please describe: \_\_\_\_\_
- 18.-Do you have problems with nightmares?..... yes no

For questions below that require a simple yes or no answer, circle your choice. For questions with a choice of numbers 1 to 5, please circle the number which best describes your condition using the grading system below:

- 1 = no problem, never occurs
- 2 = mild problem, rarely occurs
- 3 = moderate problem, happens occasionally
- 4 = moderately severe problem, occurs frequently
- 5 = severe problem, occurs very frequently

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**HOW OFTEN IS YOUR SLEEP DISTURBED DURING THE NIGHT OR AT SLEEP ONSET BECAUSE OF:**

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 19.-heat, cold, light, noise, or other bedroom conditions?.....   | 1 | 2 | 3 | 4 | 5 |
| 20.-asthma?.....  | 1 | 2 | 3 | 4 | 5 |
| 21.-shortness of breath while lying flat.....                     | 1 | 2 | 3 | 4 | 5 |
| 22.-"gas" in your stomach, indigestion, dyspepsia or heartburn... | 1 | 2 | 3 | 4 | 5 |

**HOW OFTEN DO YOU:**

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 23.-usually get up to urinate during the night? .....                | 1 | 2 | 3 | 4 | 5 |
| 24.-have nasal congestion, stuffiness, blockage during the night?... | 1 | 2 | 3 | 4 | 5 |
| 25.-snore in any way during sleep? .....                             | 1 | 2 | 3 | 4 | 5 |
| Sleeping partner's response.....                                     | 1 | 2 | 3 | 4 | 5 |
| 26.-snore loudly and disruptively? .....                             | 1 | 2 | 3 | 4 | 5 |
| Sleeping partner's response.....                                     | 1 | 2 | 3 | 4 | 5 |
| 27.-hold your breath or stop breathing during sleep? .....           | 1 | 2 | 3 | 4 | 5 |
| Sleeping partner's response .....                                    | 1 | 2 | 3 | 4 | 5 |
| 28.-wake up gasping for breath or feeling unable to breathe?         | 1 | 2 | 3 | 4 | 5 |

Sleeping partner: Please describe the breathing problems: \_\_\_\_\_

**DURING THE DAY, HOW MUCH DIFFICULTY HAVE YOU HAD:**

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 29.-daytime hallucinations or dreaming? .....                     | 1 | 2 | 3 | 4 | 5 |
| 30.-sleep paralysis, not being able to move when first waking up? | 1 | 2 | 3 | 4 | 5 |
| 31.-sudden weakness if you are surprised, upset, laughing hard?   | 1 | 2 | 3 | 4 | 5 |

32. **How likely are you to doze or fall asleep in the following situations**, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected 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

<i>Situation</i>	<i>Chance of dozing</i>
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 circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
<b>Total</b>	_____

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**MENTAL HEALTH:**

33. Check any of the following that apply to you:

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> nightmares       | <input type="checkbox"/> depression                | <input type="checkbox"/> poor memory  |
| <input type="checkbox"/> unable to relax  | <input type="checkbox"/> difficulty with decisions | <input type="checkbox"/> feel panicky |
| <input type="checkbox"/> ideas of suicide | <input type="checkbox"/> poor concentration        | <input type="checkbox"/> feel tense   |

34. Do you now see a psychiatrist or a mental health worker? ..... Yes / No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

35. Have you ever been treated for alcoholism or drug abuse?..... Yes / No

If yes please provide details: \_\_\_\_\_  
\_\_\_\_\_

36. Please add any other information about your sleep problem that you feel may be important.

\_\_\_\_\_  
\_\_\_\_\_

37. **PLEASE COMPLETE THIS SECTION IF YOU HAVE BEEN DIAGNOSED WITH OR TREATED FOR SLEEP APNEA.**

What year was your sleep apnea diagnosed? \_\_\_\_\_

What year was your last overnight sleep test? \_\_\_\_\_

**Have you ever had surgery for sleep apnea?** Yes / No

What year was your sleep apnea surgery? \_\_\_\_\_

Please describe the type of surgery that was done:

\_\_\_\_\_  
\_\_\_\_\_

**Have you ever used CPAP?** Yes / No

What year was CPAP first prescribed? \_\_\_\_\_

Do you use CPAP now? Yes / No

How many nights each week? More than 5/less than 5

How many hours each week? More than 4/less than 4

Please describe any problems you have, or had, with CPAP:

\_\_\_\_\_  
\_\_\_\_\_

**Have you used a dental appliance for sleep apnea?** Yes / No

What year was the appliance first prescribed? \_\_\_\_\_

Do you use the appliance regularly now? Yes / No

Describe any problems you have, or had, with the dental appliance:

\_\_\_\_\_  
\_\_\_\_\_