NEW PATIENT SLEEP QUESTIONNAIRE
Hoag Sleep Clinic

The purpose of this questionnaire is to obtain a comprehensive picture of your sleep and the nature of your current sleep-related problem(s). Please answer the questions as thoroughly as you can. This tool is a critical and necessary step in your evaluation and will be held in the strictest confidence. Thank you for your cooperation.

Date Completed: _____ / _____ / _____ Date of Birth: _____ / _____ / _____ Gender: _____

Name: _____ Height: _____ Weight: _____

Referring Physician: _____

Occupation: _____ Employer: _____

1. Briefly describe your chief complaint regarding your sleep:

_____

_____

_____

2. How often does this problem occur? _____

3. Please estimate the severity of your problem: ☐ Mild ☐ Moderate ☐ Severe

4. How strongly do you want help with your problem? ☐ Very much ☐ Moderately ☐ Could do without it

5. Do any other members of your family have sleep problems? ☐ Yes ☐ No

If yes, please describe: _____

_____

6. Have you consulted with a professional regarding your sleep problem? ☐ Yes ☐ No

If yes, when and with whom and when? _____

Please describe any treatments you have received: _____

_____

7. Does your sleep problem require you to cut back on social activities? ☐ Yes ☐ No

If yes, how? _____

8. Is your present work situation satisfactory? ☐ Yes ☐ No

9. During the past month, how would you rate your sleep quality? ☐ Very good ☐ Fairly good ☐ Bad ☐ Very bad

PATIENT LABEL

10. Do you usually (check all that apply):

☐ Sleep with someone else in your room

☐ Provide assistance to someone during the night (e.g., child, bed partner, animal)

11. Is your sleep often disturbed by (check all that apply):

☐ Heat ☐ Cold ☐ Noise ☐ Light ☐ Bed partner ☐ Not being in your usual bed

12. Please rate how often you:					
	Never	Rarely	Occasionally	Frequently	Always
Awaken from sleep short of breath	☐	☐	☐	☐	☐
Awaken at night with heartburn or belching	☐	☐	☐	☐	☐
Awaken at night with cough	☐	☐	☐	☐	☐
Snore	☐	☐	☐	☐	☐
Snore loudly enough that others complain	☐	☐	☐	☐	☐
Suddenly wake up gasping for breath	☐	☐	☐	☐	☐
Have breathing problems at night (observed by self or others)	☐	☐	☐	☐	☐
Sweat excessively at night	☐	☐	☐	☐	☐
Notice your heart beating irregularly during the night	☐	☐	☐	☐	☐
Fall asleep during the day	☐	☐	☐	☐	☐
Fall asleep involuntarily	☐	☐	☐	☐	☐
Fall asleep while driving	☐	☐	☐	☐	☐
Have trouble at work or school due to sleepiness	☐	☐	☐	☐	☐
Fall asleep when laughing or crying	☐	☐	☐	☐	☐
Experience loss of muscle tone when extremely emotional	☐	☐	☐	☐	☐
Feel unable to move (paralyzed) when waking or falling asleep	☐	☐	☐	☐	☐
Experience vivid dream-like scenes upon awakening or falling asleep	☐	☐	☐	☐	☐
Have nightmares affecting your daytime function	☐	☐	☐	☐	☐
Have thoughts racing through your mind	☐	☐	☐	☐	☐
Feel sad or depressed	☐	☐	☐	☐	☐
Have anxiety (worry about things)	☐	☐	☐	☐	☐
Notice parts of your body jerk	☐	☐	☐	☐	☐
Kick during the night	☐	☐	☐	☐	☐
Experience crawling and achy feelings in your legs	☐	☐	☐	☐	☐
Have morning jaw pain	☐	☐	☐	☐	☐
Grind teeth during sleep	☐	☐	☐	☐	☐
Are awakened by pain during the night	☐	☐	☐	☐	☐

PATIENT LABEL

13. Do you read or watch TV before falling asleep? ☐ Yes ☐ No

Do you drink coffee, tea, or caffeinated beverages within 2 hours of going to bed? ☐ Yes ☐ No

Do you take naps during the afternoon or evening? ☐ Yes ☐ No

If yes, how often? _____ How long do you usually nap? _____

Do you feel refreshed after a short (10-15 minute) nap? ☐ Yes ☐ No

14. What time do you usually go to bed? Weekdays _____ AM/PM Weekends _____ AM/PM

What time do you usually wake up? Weekdays _____ AM/PM Weekends _____ AM/PM

15. How many hours of sleep do you usually get per night? _____

16. If you nap during the day, how many naps do you take, at what time(s), and for how long? _____

17. How long does it take you to fall asleep? _____

18. How many times do you typically wake up at night? _____

19. If you wake up, on the average, how long do you stay awake? _____

20. What do you usually do during these awakenings? _____

21. On average, how long do you stay in bed after you wake up in the morning? _____

22. Are your sleep habits different on the weekends than during the rest of the week? ☐ Yes ☐ No

If "yes," please describe. _____

23. Do you work split or rotating shifts? _____

24. How do you feel after an average night of sleep?
☐ Consistently good ☐ Most of the time good ☐ Usually drowsy and/or tired for _____ hours

25. Have you gained or lost a lot of weight in the past few months to years? ☐ Yes ☐ No
If yes, how much? _____

26. Please list any kind of medication(s), including over-the-counter medications you are taking. If needed, please include a separate sheet for your medication list for review by the provider.

Medication Name	Medication Amount (mg)	How Often	Reason	Prescribing Provider

PATIENT LABEL

27. If you have insomnia, please attach a separate sheet of paper that summarizes **in chronological order from past to present** the following for each and all current and past medications, **including over-the-counter medications** that you have taken to treat your insomnia:

1) When you first started taking the medication
2) When you stopped taking the medication
3) Medication name
4) Medication dose
5) Medication frequency (i.e., how often you took the medication)
6) Any adverse effects you had to the medication
7) Any benefits the medication had on your insomnia
8) If the medication was prescribed, who (e.g., an internist or a psychiatrist) prescribed the medication)

28. Do you currently have any of the following conditions? (Please check all that apply.)

☐ Excessive daytime sleepiness ☐ Impaired cognition ☐ Depression/Anxiety/Other Mood Disorder
☐ Insomnia ☐ High blood pressure ☐ Ischemic Heart Disease
☐ History of stroke ☐ Congestive Heart Failure ☐ Cardiac Arrhythmias (e.g., atrial fibrillation)
☐ Asthma ☐ COPD ☐ Diabetes
☐ Kidney Problems: _____
☐ Other Cardiac Conditions: _____
☐ Other Pulmonary Conditions: _____

Please list any other significant medical problems you have that are not listed above:

_____

_____

29. Please check if you have had any of the following procedures:
☐ Tonsils/adenoids removed ☐ Nose/Jaw/Apnea surgery: _____
☐ Orthodontic work (e.g., palate expander): _____

30. List your consumption of cups/cans/ounces of the following per day:
Coffee: _____ Tea: _____ Energy Drinks: _____ Caffeinated Sodas: _____
Nicotine (please circle which type[s]: cigarettes, cigars, vaping, and/or chewing tobacco) _____ for _____ years
Alcohol (please circle which type[s]: beer, wine, vodka, other: _____): _____
Cannabis: _____ Other Non-Medication Substances Used: _____

31. What is your personal interpretation as to why you have a particular sleep/wake problem?

_____

_____

32. Employment status: ☐ Employed ☐ Disabled ☐ Retired ☐ Self-Employed
Living situation: ☐ Alone ☐ With Family ☐ Group Home ☐ Extended Care Family ☐ Other: _____

33. Please list any medication or food allergies you have and the specific allergic reactions you have:

_____

PATIENT LABEL

34. Do you use any assistive devices (e.g., wheelchair, walker, cane, etc.) ☐ Yes ☐ No
If yes, please specify: _____

35. Do you participate in an exercise program? ☐ Yes ☐ No
If yes, please specify: _____

36. As of today, please check any of the following that apply to you:

☐ Vision Problems	☐ Hearing Problems	☐ Prosthesis
☐ Nasal/Congestion/Discharge	☐ Numbness/tingling	☐ Depression
☐ Fatigue	☐ Itching	☐ Rash
☐ Use supplemental oxygen at home	☐ Cough	☐ Recent weight changes (+ or –)
☐ Shortness of Breath	☐ Dentures (upper/lower)	☐ Drug Abuse
☐ Impaired Coordination	☐ Anxious/Anxiety	☐ Apprehensive
☐ Victim of abuse/Neglect	☐ Alcohol Abuse	☐ Angry/Irritable
☐ Memory difficulties	☐ Palpitations	☐ Sweating
☐ Headaches	☐ Bowel Disturbances	☐ Can't Make Decisions
☐ Tremors	☐ Home conditions bad	☐ Stomach Trouble
☐ Aggressive	☐ Fainting Spells	☐ Dizziness
☐ Shy with People	☐ Restless	☐ Inability to Cope with Problems

37. How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 estimate 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

Situation:	Score (0, 1, 2 or 3)
1. Sitting and reading	
2. Watching TV	
3. Sitting, inactive in a public place (ex.: a theatre or meeting)	
4. As a passenger in a car for an hour without a break	
5. Lying down to rest in the afternoon when circumstances permit	
6. Sitting and talking to someone	
7. Sitting quietly after a lunch without alcohol	
8. In a car, while stopped for a few minutes in traffic	
TOTAL	

If you are using a CPAP machine (or similar device such as a BiPAP or ASV), please bring your device and accessories, including the mask, headgear, and charger/power cord to your appointment. Please arrive at least 20 minutes before your scheduled appointment time so that we can try to obtain data from your device that the doctor will want to review before the appointment begins.

If you have had any past sleep studies, please include copies and your completed New Patient Questionnaire paperwork and either e-mail these items to sleepstaff@hoag.org or bring in them in person no later than upon your check-in on the date of your scheduled appointment. Thank you.

I hereby affirm that the information submitted in response to the questions in this Hoag Sleep Clinic Questionnaire are accurate and true to the best of my knowledge.

Patient/Legal Representative Signature: _____ Date/Time: _____

If signed by other than patient, indicate relationship: _____

PATIENT LABEL