PennState Health

Address: 50 N 12th Street, Lemoyne, PA 17043
Phone: 717-234-2561

PATIENT INFORMATION

Name: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Gender: Male Female (circle one) Marital Status: Married Divorced Widowed Single (circle one)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Referring Physician: _____ Family Physician: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

NEW SLEEP PATIENT QUESTIONNAIRE

What brings you to our office today? _____

How long have you had this problem? _____

Have you seen a sleep doctor in the past? _____ If yes, who? _____ when? _____

PAST MEDICAL HISTORY

❑ Sleep apnea	❑ Insomnia	❑ Restless leg syndrome	❑ Narcolepsy
❑ COPD/Emphysema	❑ Diabetes	❑ High blood pressure	❑ Stroke
❑ Coronary artery disease	❑ Hypothyroidism	❑ Congestive heart failure	❑ Others

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Do you have any of the following in your home? (Check if applicable):

❑ Oxygen ❑ Nebulizer machine ❑ CPAP/BiPAP

If yes, who is your medical supplier (DME)? _____

PAST SURGICAL HISTORY

❑ CABG (bypass surgery)	❑ Heart valve replacement	❑ Appendectomy
❑ Cholecystectomy (gall bladder removal)	❑ Nasal surgery	❑ Other surgeries

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ALLERGIES

❑ Medications ❑ None ❑ Yes _____

FAMILY HISTORY

Check if applicable, and list which family member has the condition:

Condition	Yes	Who	Condition	Yes	Who
Sleep apnea	_____	_____	High blood pressure	_____	_____
Narcolepsy	_____	_____	Heart disease	_____	_____

SOCIAL HISTORY

Do you smoke?_____Have you ever smoked?_____If yes, how many packs per day?_____

How many years have you been smoking?_____ If no longer smoking, when did you quit? _____

How many years did you smoke before you quit?_____Does anyone in your house smoke?_____

Do you drink alcohol?_____ If yes, how often?_____

Do you use street drugs?_____ What is/was your occupation?_____

SLEEP HISTORY QUESTIONNAIRE

- ☐ I have been told that I snore.
- ☐ I have been told that I stop breathing when I sleep
- ☐ I have high blood pressure.
- ☐ My friends and family stay that I'm grumpy and irritable.
- ☐ I have fallen asleep while driving.
- ☐ I have noticed my heart pounding or beating irregularly during the night.
- ☐ I get morning headaches.
- ☐ I suddenly wake gasping for breath.
- ☐ I am overweight.
- ☐ I seem to be losing my sex drive.
- ☐ I often feel difficulty falling asleep.
- ☐ I frequently wake with a dry mouth.
- ☐ I have difficulty falling asleep.
- ☐ Thoughts race through my mind and prevent me from sleeping.
- ☐ I anticipate a problem with sleep several times a week.
- ☐ I wake up and cannot go back to sleep.
- ☐ I worry about things and have trouble relaxing.
- ☐ I wake up earlier in the morning than I would like to.
- ☐ I like awake for half an hour or more before I fall asleep.
- ☐ When I am angry or surprised, I feel like my muscles go limp.
- ☐ I often feel like I am in a daze.
- ☐ I have experienced vivid dreamlike scenes.
- ☐ I have fallen asleep in social settings such as the movies or at a party.
- ☐ I have trouble at work because of sleepiness.
- ☐ I have dreams soon after falling asleep or during naps.
- ☐ I have "sleep attacks" during the day no matter how hard I try to stay awake.
- ☐ I have had episodes of feeling paralyzed during my sleep or on awakening.
- ☐ Other than when exercising, I still experience muscle tension in my legs.
- ☐ I have noticed (or others have commented) that parts of my body jerk during sleep.
- ☐ I have been told I kick at night.
- ☐ When trying to go to sleep, I experience an aching or crawling sensation in my legs.
- ☐ I experience leg pain and cramps at night.
- ☐ Sometimes I can't keep my legs still at night. I just have to move them to feel comfortable.
- ☐ Even though I slept during the night, I feel sleepy during the day.

Patient Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS

General	☐ Weight loss	☐ Weight gain	☐ Fever	☐ Fatigue	☐ Night sweats
Sleep	☐ Excessive sleepiness	☐ Snoring	☐ Non-refreshing sleep	☐ Sleep walking	☐ Insomnia
ENT	☐ Post nasal drip	☐ Sinus congestion	☐ Nasal polyps	☐ Hoarseness	☐ Ulcers in mouth
Respiratory	☐ Shortness of breath	☐ Chronic cough	☐ Coughing up blood	☐ Wheezing	☐ Pleurisy
Cardiovascular	☐ Chest pain	☐ Leg swelling	☐ Palpitation	☐ Passing out	☐ Irregular heartbeat
Gastrointestinal	☐ Swallowing difficulty	☐ Acid reflux	☐ Abdominal pain	☐ Vomiting	☐ Blood in stool
Genitourinary	☐ Frequent urination	☐ Incontinence	☐ Hesitancy	☐ Urgency	☐ Blood in urine
Musculoskeletal	☐ Joint stiffness	☐ Joint pain	☐ Back pain	☐ Muscle weakness	☐ Muscle pain
Hematology	☐ Lymph gland swelling	☐ Blood clots	☐ Easy bruising	☐ Cancer	☐ Anemia
Nervous system	☐ Weakness	☐ Tremors	☐ Headache	☐ Dizziness	☐ Restless legs
Endocrinology	☐ Loss of appetite	☐ Cold intolerance	☐ Heat intolerance	☐ Goiter	☐ Excessive thirst
Skin	☐ Jaundice	☐ Eczema	☐ Itching	☐ Hair loss	☐ Rash

MEDICATIONS

Please write or provide a list of ALL medications you are currently taking, including prescription, over-the-counter, herbal supplements and any inhalers.

	MEDICATION NAME	DOSE	FREQUENCY
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			

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OBSTRUCTIVE SLEEP APNEA SCREENING

STOP- BANG QUESTIONNAIRE

STOP QUESTIONS

1. **S**noring – Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
2. **T**ired - Do you often feel tired, fatigued, or sleepy during the daytime?	Yes	No
3. **O**bserved breathing pattern - Has anyone observed you stop breathing during your sleep?	Yes	No
4. Blood **P**ressure - Do you have or are you being treated for high blood pressure?	Yes	No

BANG QUESTIONS

5. **B**MI - BMI more than 35?	Yes	No
6. **A**ge - Age over 50 year old?	Yes	No
7. **N**eck Circumference - Is your neck size greater than 40 cm (approx. 15.75 inches)?	Yes	No
8. **G**ender - Gender Male?	Yes	No

TOTAL SCORE: _____

EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. Use the following scale to choose the most appropriate number for each situation over the past two weeks. Even if you don't usually do this activity, please give your best estimate:

0 = would *never* doze or sleep.
1 = *slight* chance of dozing or sleeping
2 = *moderate* chance of dozing or sleeping
3 = *high* chance of dozing or sleeping

Situation	***Chance of dozing/sleeping***			
• Sitting and reading	0	1	2	3
• Watching TV	0	1	2	3
• Sitting inactive in a public place	0	1	2	3
• Being a passenger in a motor vehicle for an hour or more	0	1	2	3
• Lying down in the afternoon	0	1	2	3
• Sitting and talking to someone	0	1	2	3
• Sitting quietly after lunch (no alcohol)	0	1	2	3
• Stopped for a few minutes in traffic	0	1	2	3

TOTAL SCORE: _____

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