



New Patient Questionnaire

Name _____ Date of Birth: _____

Height _____ Weight _____

Referring Physician _____

Primary Care Physician _____

What is your main problem while trying to sleep? _____

What is your normal bedtime? _____ What is your normal rise time? _____

Do you use an alarm clock to wake up in the morning? _____

How long does it take to go to sleep? _____

Do you take naps? Yes No If so, how long do they usually last? _____

How much sleep do you feel you get at night? _____

How many times do you feel you awake during the night? _____

Do you feel rested in the morning? Yes No

Does your spouse complain that you disturb them at night? Yes No

Has anyone in your family been diagnosed with a sleep disorder? Yes No

Have you previously been diagnosed with a sleeping disorder? Yes No

If so, when, where and by whom? _____

Who lives in your household? _____

What kind of work do you do and what are your typical work

hours: _____

Please circle one:

Do you snore?	Never	Rarely	Sometimes	Frequently
Do you cough at night?	Never	Rarely	Sometimes	Frequently
Do you have morning headaches?	Never	Rarely	Sometimes	Frequently
Do you have night sweats?	Never	Rarely	Sometimes	Frequently
Do you have nightmares?	Never	Rarely	Sometimes	Frequently
Do you sleep walk?	Never	Rarely	Sometimes	Frequently
Do you sleep talk?	Never	Rarely	Sometimes	Frequently
Do you feel weak when you get emotional?	Never	Rarely	Sometimes	Frequently
Are you short-tempered?	Never	Rarely	Sometimes	Frequently
Do you have trouble concentrating?	Never	Rarely	Sometimes	Frequently
Does pain keep you awake?	Never	Rarely	Sometimes	Frequently
Do your legs feel restless at night?	Never	Rarely	Sometimes	Frequently
Do your legs ache or hurt at night?	Never	Rarely	Sometimes	Frequently
Do your legs jerk at night?	Never	Rarely	Sometimes	Frequently
Do you fall asleep at inappropriate times?	Never	Rarely	Sometimes	Frequently

Modified Epworth Sleepiness Scale

Instructions: Being as truthful as possible, circle the best answer for each of the following situations:

Sitting and Reading (even if you don't normally read, would you fall asleep if you sat down to read a book, look at the paper, or look at a magazine)...

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Watching Television...

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Sitting inactive in a public place, for example church, a movie, or a meeting...

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Riding as a passenger in a car for a long trip (over an hour). Even if you don't normally ride as a passenger, would you fall asleep on a long trip if you did?...

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Lying down to rest in the afternoon (even if you don't normally nap, if you laid down to rest, would you fall asleep?)...

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Sitting and talking to someone...

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Sitting quietly after lunch (even if you don't normally sit down after lunch, if you did sit quietly after lunch, would you fall asleep?)...

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Driving a car, either stopped at a light or driving down the road...

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing