Dallas Diagnostic Association – Pulmonary & Critical Care
Dr Mari Adachi M.D. Dr Omar Awad M.D., F.C.C.P.
4716 Alliance Blvd – Suite 700
Plano, TX 75093
(469) 800-6036

New Patient Form

SLEEP QUESTIONNAIRE

Patient Information:

Name:_____ D.O.B: _____ Today's Date: _____

Occupation: _____ Shift: _____

Do you currently drive? Yes ☐ No ☐ If yes, what state is your driver's license issued? _____

Have you ever had a sleep study? Yes ☐ No ☐ If yes, where & when? _____

Are you currently using CPAP? Yes ☐ No ☐ If yes, what company is your machine from? _____

Sleep Problems:

Please describe why you are here today: _____

_____

General Sleep Information:

What time do you go to bed? _____

How long does it usually take to fall asleep? _____

How many times do you wake up in a typical night? _____

What time do you usually wake up in the morning? _____

How many hours of sleep do you usually get? _____

Do you often wake up in the morning with a headache? Yes ☐ No ☐

Do you usually fall asleep with the TV on? Yes ☐ No ☐

Do you keep the TV on throughout the night? Yes ☐ No ☐

Night Time Symptoms:

1. Do you snore loudly at night? Yes ☐ No ☐
2. Does a bed partner move out of the bedroom because of your snoring? Yes ☐ No ☐
3. Do you ever stop breathing during your sleep? Yes ☐ No ☐
4. Do you ever wake up choking? Yes ☐ No ☐
5. Have you ever been unable to move shortly after going to sleep or when waking up? Yes ☐ No ☐
6. Do your legs jerk when you sleep? Yes ☐ No ☐

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Night Time Symptoms continued:

7. Do you sometimes have an urge to move your legs, often associated with uncomfortable leg sensation? Yes ☐ No ☐
8. Do you get relief, at least temporarily, from the urge or leg sensations when you move? Yes ☐ No ☐
9. Do your leg symptoms begin or get worse when you are resting or inactive? Yes ☐ No ☐
10. Do your leg symptoms get worse in the evening or at night? Yes ☐ No ☐
11. Do you walk or talk in your sleep? Yes ☐ No ☐
12. Did you walk or talk in your sleep as a child? Yes ☐ No ☐
13. Do you grind your teeth during sleep? Yes ☐ No ☐
14. As an adult, have you ever wet the bed during your sleep? Yes ☐ No ☐
15. How many times do you awaken at night to go to the bathroom? _____

Daytime Symptoms:

1. Are you drowsy or sleepy during the day? Yes ☐ No ☐
2. Does daytime sleepiness interfere with your work? Yes ☐ No ☐
3. Have you fallen asleep while driving or eating? Yes ☐ No ☐
4. How many naps (if any) do you take per day? _____
5. How long is you longest nap? _____ Hrs/mins
6. Does a nap make you feel more alert? Yes ☐ No ☐
7. Do you have vivid dreams during daytime naps? Yes ☐ No ☐
8. Do you drink coffee, tea, cola, or take any caffeine to stay awake? Yes ☐ No ☐
9. Do you ever fall or lose muscle strength while laughing? Yes ☐ No ☐

Emotional:

Are you now, or have you in the past had serious depression? Yes ☐ No ☐
Are you now, or have you in the past had major anxiety? Yes ☐ No ☐
Is your sleep problem causing emotional problems? Yes ☐ No ☐
Are you currently under stress because of work or family? Yes ☐ No ☐
Do you find that your sleep problems have diminished your interest in sexual activities? Yes ☐ No ☐

Additional Comments: _____

_____

_____

Other concerns: _____ **I need medications refilled** _____

Do you smoke? ☐ Yes ☐ No If yes, how much? _____ When did you quit? _____

Baylor Scott & White HEALTH

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Past History (Check all that apply)

☐ Asthma	☐ Emphysema	☐ Pneumonia	☐ Cancer
☐ Tuberculosis	☐ Diabetes	☐ Stroke	☐ High Blood Pressure
☐ Seizures	☐ Thyroid Problems	☐ Liver Problems	☐ Ulcers
☐ Kidney Problems	☐ Heart Attack	☐ Heart Problems	☐ Arthritis
☐ Bleeding Problems	☐ COPD Chronic	☐ Bronchitis	☐ Pleural Effusion
☐ Hypertension			

Please list all past surgery(s): _____

_____

Social History

Do you smoke? ☐ Yes ☐ No If yes, how much? _____

When did you quit? _____

Have you ever tried Cocaine, Heroin, Amphetamine, Marijuana, or any other illicit drugs?

Occupation: _____ Marital status: _____

Children: _____ Pets: _____

Any recent travel(s)? _____

Family History

Relationship	Age (if living)	Age at death	State of health/Cause of death
Mother:			
Father:			
Sister(s):			
Brother(s):			
Children:			

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EPWORTH SLEEPINESS SCALE

Name: _____ DOB: _____ Today's Date: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

Use the following scale to choose the most appropriate answer for each of the following:

0 = would **NEVER** dose

1 = **SLIGHT** chance of dozing

2 = **MODERATE** chance of dozing

3 = **HIGH** chance of dozing

Sitting and reading ---------- _____

Watching TV ---------- _____

Sitting inactive in a public place (theater, meeting, etc) ---------- _____

As a passenger in a car for an hour without a break ---------- _____

Lying down to rest in the afternoon when able ---------- _____

Sitting and talking to someone ---------- _____

Sitting quietly after a lunch without alcohol ---------- _____

In a car while stopped for a few minutes in traffic ---------- _____

TOTAL _____