VCU CENTER FOR SLEEP MEDICINE
NEW PATIENT QUESTIONNAIRE

Date: ____________  Sex: _____  Age: _____  Height: _____

Referring physician: _________________________________________________
Primary care physician: ______________________________________________

What is your primary sleep problem? __________________________________

Please explain any strange feelings or behavior you have or had during the night.
___________________________________________________________________

Who initially suspected a sleep problem? __________________________________

Do you currently have a bed partner/roommate? _____ Yes _____ No

If yes, please have them assist you with this questionnaire.

Have you been seen by a sleep specialist before? __________________________

On weekdays I sleep _____ hours, mostly from _____ to _____.

On weekends I sleep _____ hours, mostly from _____ to _____.

In what position(s) do you normally sleep? _______________________________ 

Do you take frequent naps during the day? _____ Yes _____ No

If yes, how many days a week?

How long is the nap?

What time of day is the nap?

Are they refreshing? _____ Yes _____ No

Have you ever fallen asleep while driving? _____ Yes _____ No

If yes, did a motor vehicle accident occur? _____ Yes _____ No

On scale of 1 to 10 where 1 is very bad and 10 is very good, how would you rate your sleep overall?

____________________________________

Sleep/Social History

How many caffeinated drinks do you have daily? ___________________________

What time is the last caffeinated drink of the day? __________________________

Do you exercise regularly? _____ Yes _____ No

Have you ever used diet pills? _____ Yes _____ No

Have you ever used stimulant drugs before? _____ Yes _____ No

Do you currently smoke cigarettes? _____ Yes _____ No

Have you ever smoked cigarettes?

How many packs per day?

How many years did you smoke?

Have you quit smoking yet? _____ Yes _____ No

How much alcohol do you consume within three hours of bedtime? __________

How much alcohol do you consume within a 24-hour period? _______________

Do you or have you ever used recreational drugs? _____ Yes _____ No

If yes, what type of drug? ____________________________________________

What is your occupation? _____________________________________________

Level of education? (circle one) High School  College  Graduate/Professional

Marital Status (circle one) Single  Married  Separated  Divorced  Widowed

Do you live alone? _____ Yes _____ No

If no, with whom do you live? _________________________________________

Have you recently traveled? _____ Yes _____ No

If yes, where? _______________________________________________________

Have you ever served in the military? _____ Yes _____ No

If yes, did you see combat? _____ Yes _____ No

Name:________________________
DOB:________________________
MR#:________________________
Family History:
Please provide any medical problems and sleep issues for the following

Mother ______________________________________________________
Father ______________________________________________________
Siblings _____________________________________________________
Children _____________________________________________________

Allergies: Please list any medication allergies or drug reactions you have or have had.

Drug: ___________________ Reaction: ____________________________
Drug: ___________________ Reaction: ____________________________

Medications: Please list any medication you are currently taking with the dose and how often they are taken. Include over-the-counter sleeping pills such as Melatonin and include as well any herbal remedies and vitamins/supplements. If you have provided a list to the front desk you may skip this question.

1. _________________________________________________________ 6. _________________________________________________________
2. _________________________________________________________ 7. _________________________________________________________
3. _________________________________________________________ 8. _________________________________________________________
4. _________________________________________________________ 9. _________________________________________________________
5. _________________________________________________________ 10. _________________________________________________________

Medical History: Have you now or in the past experienced any health problems in the following areas?

_____ High blood pressure  _____ Shortness of breath
_____ Deviated nasal septum  _____ Chronic cough
_____ Sinus problems  _____ Asthma
_____ Tonsillectomy  _____ Emphysema
_____ Heart Disease  _____ Thyroid Disease
_____ Psychiatric (depression, anxiety)  _____ Diabetes
_____ Stroke / TIA  _____ Heartburn / Reflux
_____ Fibromyalgia  _____ Chronic pain

Please list any other medical problems you have or have had:
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Please list any surgeries you have had:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Date</th>
<th>Procedure</th>
<th>Date</th>
</tr>
</thead>
<tbody>
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</table>

Do you have any specific questions you wish to ask your sleep clinician?
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Name: ______________________
DOB: ______________________
MR#: ______________________
Are you currently having any of the following problems?  
*Check all that apply*

**Constitution:**
- ☐ Fever  ☐ Chills  ☐ Weight Loss
- ☐ Weight Gain

**Eyes:**
- ☐ Blurred/Double Vision  ☐ Floaters  ☐ Eye pain

**Ears, Nose, Throat:**
- ☐ Hearing Loss  ☐ Ringing  ☐ Congestion
- ☐ Imbalance  ☐ Difficulty Swallowing

**Cardiovascular:**
- ☐ Chest Pain  ☐ Irregular Beats
- ☐ Swelling in Legs

**Respiratory:**
- ☐ Coughing  ☐ Wheezing
- ☐ Short of Breath

**Gastrointestinal:**
- ☐ Nausea  ☐ Vomiting  ☐ Heartburn
- ☐ Constipation  ☐ Diarrhea
- ☐ Stomach Pain  ☐ Blood in Stool

**Endocrine:**
- ☐ Excessive Thirst  ☐ Sweating
- ☐ Too hot/cold

**Genitourinary:**
- ☐ Overnight Urination  ☐ Incontinence
- ☐ Painful Urination  ☐ Urinary Frequency
- ☐ Bleeding with Urination  ☐ Decrease Sex Drive  ☐ Impotence  ☐ Menstrual Problems

**Musculoskeletal:**
- ☐ Pain in Muscles/Joints  ☐ Swelling
- ☐ Weakness  ☐ Recent falls  ☐ Leg Movements Before/During Sleep

**Skin:**
- ☐ Rash/Hives  ☐ Pain  ☐ Itching

**Neurologic:**
- ☐ Numbness/Tingling  ☐ Headache  ☐ Dizziness
- ☐ Seizure  ☐ Loss of Consciousness

**Psychological:**
- ☐ Mood Problems  ☐ Depression  ☐ Anxiety
- ☐ Increased Life Stressors  ☐ Crying Spells  ☐ Thoughts of Suicide

**Lymph/Heme:**
- ☐ Seasonal Allergies  ☐ Food Allergies
- ☐ Bleeding/ Bruising Problems

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**How sleepy have you been over the last 4 weeks?**

<table>
<thead>
<tr>
<th>Situation</th>
<th>Low</th>
<th>1</th>
<th>2</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Watching TV</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sitting inactive in a public place</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Being a passenger in a motor vehicle for an hour or more</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Lying down in the afternoon</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sitting quietly after lunch (no alcohol)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Stopped for a few minutes in traffic while driving</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total Score (add up the circled numbers)**

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Name:_______________________
DOB:_______________________
MR#:________________________
Sleep Questions: Please respond to what extent a statement (item) has been applicable to you during the past 4 weeks. Score each item on a 4-point-scale:
1 (not at all) 2 (somewhat) 3 (rather much) 4 (very much)

Section 1: _____

1. I am told that I snore. 1 2 3 4
2. I sweat during the night. 1 2 3 4
3. I am told that I hold my breath when sleeping. 1 2 3 4
4. I am told that I wake up gasping for air. 1 2 3 4
5. I wake up with a dry mouth. 1 2 3 4
6. I wake up during the night while coughing or being short of breath. 1 2 3 4
7. I wake up with a sour taste in my mouth. 1 2 3 4
8. I wake up with a headache. 1 2 3 4

Section 2: _____

9. I have difficulty in falling asleep. 1 2 3 4
10. Thoughts go through my head and keep me awake. 1 2 3 4
11. I worry and find it hard to relax. 1 2 3 4
12. I wake up during the night. 1 2 3 4
13. After waking up during the night, I fall asleep slowly. 1 2 3 4
14. I wake up early and cannot get back to sleep. 1 2 3 4
15. I sleep lightly. 1 2 3 4
16. I sleep too little. 1 2 3 4

Section 3: _____

17. I see dreamlike images when falling asleep or waking up. 1 2 3 4
18. I sometimes fall asleep on a social occasion. 1 2 3 4
19. I have sleep attacks during the day. 1 2 3 4
20. With intense emotions, my muscles sometimes collapse during the day. 1 2 3 4
21. I sometimes cannot move when falling asleep or waking up. 1 2 3 4

Section 4: _____

22. I am told that I kick my legs when I sleep. 1 2 3 4
23. I have cramps or pain in my legs during the night. 1 2 3 4
24. I feel little shocks in my legs during the night. 1 2 3 4
25. I cannot keep my legs at rest when falling asleep. 1 2 3 4

Name:_______________________
DOB:________________________
MR#:________________________

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Section 5: _____

26. I would rather go to bed at a different time. 1 2 3 4
27. I go to bed at very different times (more than 2 hr difference). 1 2 3 4
28. I do shift work. 1 2 3 4

Section 6: _____

29. I sometimes walk when I am sleeping. 1 2 3 4
30. I sometimes wake up in a different place than where I fell asleep. 1 2 3 4
31. I sometimes find evidence of having performed an action during the night I do not remember.

Section 7: _____

32. I have frightening dreams (if not, go to Item 37). 1 2 3 4
33. I wake up from these dreams. 1 2 3 4
34. I remember the content of these dreams. 1 2 3 4
35. I can orientate quickly after these dreams. 1 2 3 4
36. I have physical symptoms during or after these dreams (e.g., movements, sweating, heart palpitations, shortness of breath).

Section 8: _____

37. It is too light in my bedroom during the night. 1 2 3 4
38. It is too noisy in my bedroom during the night. 1 2 3 4
39. I drink alcoholic beverages during the evening. 1 2 3 4
40. I smoke during the evening. 1 2 3 4
41. I use other substances during the evening (e.g., sleep or other medication). 1 2 3 4
42. I feel sad. 1 2 3 4
43. I have no pleasure or interest in daily occupations. 1 2 3 4

Section 9: _____

44. I feel tired at getting up. 1 2 3 4
45. I feel sleepy during the day and struggle to remain alert. 1 2 3 4
46. I would like to have more energy during the day. 1 2 3 4
47. I am told that I am easily irritated. 1 2 3 4
48. I have difficulty in concentrating at work or school. 1 2 3 4
49. I worry whether I sleep enough. 1 2 3 4
50. Generally, I sleep badly. 1 2 3 4

Name:_______________________
DOB:________________________
MR#:________________________