VCU CENTER FOR SLEEP MEDICINE
NEW PATIENT QUESTIONNAIRE

Name:_____
DOB:_____
MR#:_____

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? _____ Yes _____ No
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

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

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

Please list any surgeries you have had:

Procedure	Date
_____	_____
_____	_____
_____	_____

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

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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

How sleepy have you been over the last 4 weeks?

Situation	Chance of Dozing or Sleeping (circle the most appropriate number) Low			High
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 while driving……	0	1	2	3

Total Score (add up the circled numbers)……. _____

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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

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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.	1	2	3	4

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).	1	2	3	4

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

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