Patient Sleep Questionnaire

PATIENT NAME: _____

HEIGHT: _____ (ft) _____ (in) **WEIGHT:** _____ (lbs) **BMI:** _____ **NECK SIZE**: _____ (in) **DOB**: ___/___/_____

BRIEFLY DESCRIBE YOUR SLEEP CONCERNS: _____

DO YOU HAVE A HISTORY OF THE FOLLOWING? CHECK ALL THAT APPLY.

- ☐ Snoring
- ☐ Witnessed Pauses in Breathing
- ☐ Choking & Gasping
- ☐ Sleepiness
- ☐ Fatigue
- ☐ Headaches
- ☐ Memory Loss
- ☐ Depression
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Erectile Dysfunction
- ☐ Other (specify) _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Do you have a family history of sleep apnea? ☐ Yes ☐ No

Do you have any lung or breathing problems? ☐ Yes ☐ No

If yes, please describe. _____

Do you have a Pacemaker? ☐ Yes ☐ No

Do you use oxygen at night? ☐ Yes ☐ No

Do you get up to go to the bathroom frequently during the night? ☐ Yes ☐ No

Have you ever had oral or nasal surgery? ☐ Yes ☐ No

If yes, please describe. _____

Do you drink alcohol? ☐ Yes ☐ No

How often? (CKeǒ] all that apply)

☐ Daily ☐ 3-5 times a week ☐ Once a week ☐ Only on weekends ☐ On special occasions

Any recent change in your intake of alcohol? ☐ Yes ☐ No

If yes, please describe: _____

PLEASE LIST ALL OF YOUR MEDICATIONS, INCLUDING OVER THE COUNTER:

The above information is true and correct to the best of my belief.

Signature _____ Date _____

FAX COMPLETED FORM TO 215-933-5261

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