FAUQUIER HEALTH
Sleep Center

Patient Questionnaire

Date: _____

Name: _____D.O.B. _____/_____/_____

Address: _____

Phone: _____ Referring Physician: _____

Hight _____ Neck Circumference (if known) _____

Weight _____

SLEEP HISTORY: ***Circle where apply***

1. What time do you go to bed? _____ .
2. How long does it take for you to fall asleep? _____.
3. How much sleep do you get in hours each night? _____ .
4. Do you wake up in the middle of the night: Yes No
5. If yes, how often? _____ .
6. Do you snore: Yes No Not sure
7. Has anyone seen you stop breathing while sleeping? Yes No
8. If yes, who? _____ .
9. Have you woken yourself up with: Gasping for air Shortness of breath Snorting
10. Do you have excessive daytime sleepiness? Yes No Sometimes
11. Have you gained or lost weight in the last couple of years? Gained Lost
    How many lbs.: _____
12. Any motor vehicle accidents due to sleepiness? Yes No
13. Any Restless Leg Syndrome that interferes with your sleep? Yes No Sometimes
14. Do you kick your legs during sleep? Yes No Sometimes
15. Do you experience weakness in your legs with a sudden emotional change (like laughter, surprise, anger)? Yes No
16. Do you experience hallucinations while drifting to sleep or waking up? Yes No
17. Do you experience Sleep Paralysis? Yes No

PAST MEDICAL HISTORY (include diagnosis):

_____

_____

Have you ever had a sleep study? Yes No When?

_____

Have you ever been diagnosed with Obstructive sleep apnea? Yes No

If yes, do you use CPAP? Yes No

What Durable Medical Equipment (DME) company do you use? _____

Any problem using CPAP therapy? Yes No

If yes, explain: _____

Have you tried treatments other than CPAP? Example: Dental Device ENT Surgery

ALLERGIES TO MEDICATIONS: Yes No

If yes, name the medications: _____

CURRENT MEDICATIONS:

_____
_____
_____
_____
_____

FAMILY HISTORY:

Anyone in the family who has sleep disorder

_____
_____
_____

SOCIAL HISTORY:

Marital Status: Single Married Engaged Divorced Separated Widow

Number of Children: _____

What do you do for a living? _____

Do you drink caffeinated beverages?

Coffee: Yes No How much? _____Oz_____

Tea: Yes No How much? _____

Soda: Yes No How much? _____

Energy Drink: Yes No How much? _____

Do you drink alcohol: Yes No how much?

Type: Beer Wine Vodka Mixed drinks others

What time do you drink alcohol? _____

What is your preferred language? _____

What is your primary language? _____

Do you need an interpreter? _____ Yes _____ No

What is your preferred method of learning: _____ Verbal _____

Demonstration? _____Written _____ Audio/visual

Vision? (Circle one) Intact Contacts Glasses for Reading Glasses at all times other

Hearing? (Circle one)

Left ear Intact Hard of Hearing Hearing Aid Deaf Other

Right ear Intact Hard of Hearing Hearing Aid Deaf Other

Do you have any cultural, ethnic, or spiritual concerns regarding your care? _____

_____ .