National Jewish Health®
Breathing Science is Life.®

**#1 respiratory hospital in the U.S.**
*US News & World Report*

**Sleep Center**

*Main Campus*
1400 Jackson Street
Denver, CO 80206

*Highlands Ranch Location*
8671 S. Quebec St., Ste 120
Highlands Ranch, CO 80130

*DTC Location – Testing Only*
7877 South Chester St
Englewood, CO 80112

*Thornton Location*
9451 Huron St
Thornton, CO 80260

303.270.2708
303.270.2109 Fax

# Sleep Center New Patient Questionnaire

**PRIOR TO SCHEDULING:**

1. Patient to submit completed questionnaire. Fax (303)270-2109
2. If required by patient's insurance, an authorization and/or referral needs to be sent to National Jewish Health Sleep Center.

Patient Name:_____ Date of birth:_____
Street Address:_____ City/State:_____
Phone Number: _____ Home Mobile Work (circle one)
Referring Physician/PCP_____ Primary Insurance:_____

**Chief Complaint**
Please describe the reason for your visit and chief complaint/s:

_____

Have you had a previous sleep study? Yes ☐ No ☐
If so, when and where? When:_____
Name of facility:_____

Do you have a diagnosis of Sleep Apnea? Yes ☐ No ☐
Are you on a PAP therapy device? ☐ Yes ☐ No If so, what are your settings?_____
If so, please bring your equipment to each Sleep Clinic appointment.
Are you on oxygen? ☐ Yes ☐ No If so, how much?_____
If you currently receive medical equipment, what is the name of your equipment company?

_____

**How likely are you to doze off or fall asleep in the following situations?**
This refers to your usual way of life in recent times. If you have not done some of these things recently, try to estimate how they might have affected you. Use the following scale to rate your chance of dozing in the following situations:

**0 – Never 1 – Slight chance 2 – Moderate chance 3 – High chance**

| **Situations** | **Score** |
|---|---|
| Sitting and reading | |
| Watching TV | |
| Sitting, inactive, in a public place | |
| As a passenger in a car for an hour without a break | |
| Lying down to rest in the afternoon | |
| Sitting and talking to someone | |
| Sitting quietly after a lunch without alcohol | |
| In a car, while stopped for a few minutes in traffic | |
| **Total Score** | |

Reference: Johns MW. A new method for measuring daytime sleepiness: the Epworth sleepiness scale. Sleep. 1991 Dec;14(6):540-5.

Patient Name:_____

**Sleep History**

Do you **currently** experience any of the following: (please check all that apply)

| | Yes | No |
|---|---|---|
| 1. Excessive daytime sleepiness | ☐ | ☐ |
| 2. Drowsy driving | ☐ | ☐ |
| 3. Have you had a recent accident or near miss due to drowsiness | ☐ | ☐ |
| 4. Insomnia (difficulty falling asleep or staying asleep) | ☐ | ☐ |
| 5. Frequent snoring | ☐ | ☐ |
| 6. Wake up gasping, choking or feeling short of breath | ☐ | ☐ |
| 7. Witnessed apneas (breath holding during sleep) | ☐ | ☐ |
| 8. Excessive sweating during sleep | ☐ | ☐ |
| 9. Nighttime heartburn | ☐ | ☐ |
| 10. Headaches on awakening | ☐ | ☐ |
| 11. Unpleasant sensations in your legs at night or at bedtime | ☐ | ☐ |
| 12. Twitching or jerking of your legs during sleep | ☐ | ☐ |
| 13. Frequent disturbing dreams or nightmares | ☐ | ☐ |
| 14. Unusual movements or behavior during asleep | ☐ | ☐ |
| 15. Sleepwalking | ☐ | ☐ |
| 16. Losing muscle strength when laughing, excited or angry | ☐ | ☐ |
| 17. Imagine seeing or hearing things as you fall asleep or wake up | ☐ | ☐ |
| 18. Feeling unable to move (paralyzed) as you fall asleep or wake up | ☐ | ☐ |
| 19. Teeth clenching/grinding | ☐ | ☐ |

**Sleep Schedules**

| | Weekdays | | Weekends |
|---|---|---|---|
| 1. What time do you get into bed at night? | _____ | | _____ |
| 2. Do you watch TV, read, use computer in bed? | ☐ Yes | ☐ No | |
| 3. What time do you try to fall asleep? | _____ | | _____ |
| 4. Time it takes to fall asleep (minutes): | _____ | | _____ |
| 5. Wake time: | _____ | | _____ |

6. Number of awakenings per night:_____
   If yes, what causes these awakenings?_____
7. Average number of hours of sleep per night:_____
8. How do you feel when you wake up? _____
9. Do you take naps during the day? ☐ Yes ☐ No
   If so, how long are the naps? _____
   What time do you usually nap? _____
10. Do you do shift work or work at night? ☐ Yes ☐ No

**Childhood Sleep Disorder**

Did you have any of the following as a child: (please check all that apply)

| | Yes | No |
|---|---|---|
| 1. Snoring | ☐ | ☐ |
| 2. Sleep apnea | ☐ | ☐ |
| 3. Insomnia | ☐ | ☐ |
| 4. Excessive sleepiness | ☐ | ☐ |

Patient Name:_____

**Medical, Neurological or Psychiatric History**
Please list the health problems you have had:

| | Yes | No |
|---|---|---|
| 1. Hypertension | ☐ | ☐ |
| 2. Heart failure | ☐ | ☐ |
| 3. Abnormal cardiac rhythm | ☐ | ☐ |
| 4. Heart attack | ☐ | ☐ |
| 5. Asthma | ☐ | ☐ |
| 6. Chronic obstructive pulmonary disease | ☐ | ☐ |
| 7. Reflux | ☐ | ☐ |
| 8. Diabetes | ☐ | ☐ |
| 9. Thyroid disorder | ☐ | ☐ |
| 10. Stroke | ☐ | ☐ |
| 11. Seizures | ☐ | ☐ |
| 12. Parkinson disease | ☐ | ☐ |
| 13. Dementia | ☐ | ☐ |
| 14. Head trauma | ☐ | ☐ |
| 15. Depression | ☐ | ☐ |
| 16. Anxiety disorder | ☐ | ☐ |
| 17. Post-traumatic stress disorder | ☐ | ☐ |
| 18. Attention deficit hyperactivity disorder | ☐ | ☐ |

19. Other: _____

_____

**Surgical History**
Please check the surgeries you have had:

| | Yes | No |
|---|---|---|
| 1. Tonsillectomy-adenoidectomy | ☐ | ☐ |
| 2. Nasal surgery | ☐ | ☐ |
| 3. Sinus surgery | ☐ | ☐ |
| 4. Palate surgery for sleep apnea | ☐ | ☐ |
| 5. Gastric bypass surgery | ☐ | ☐ |
| 6. Heart surgery | ☐ | ☐ |

7. Other: _____

**Family History**
Do any of your family members experience the following sleep disorders: (please check all that apply)

| | Yes | No |
|---|---|---|
| 1. Snoring | ☐ | ☐ |
| 2. Sleep apnea | ☐ | ☐ |
| 3. Insomnia | ☐ | ☐ |
| 4. Excessive sleepiness | ☐ | ☐ |
| 5. Narcolepsy | ☐ | ☐ |
| 6. Restless legs syndrome | ☐ | ☐ |

7. Parents: living or deceased, medical history _____
8. Siblings: _____
9. Other family history? _____

Patient Name:_____

**Medications**

Please list current medications (Current National Jewish Health patients may skip):

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

Please list medications you have taken for your sleep problem:

1. _____
2. _____
3. _____
4. _____

**Drug Allergies**

Please list drug and medication allergies (Current National Jewish Health patients may skip):

1. _____
2. _____
3. _____

**Social History**

Please check one:

1. Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
2. Occupation:_____
3. Children and ages:_____

4. Caffeinated coffee: ☐ Yes ☐ No
If yes, how much: _____ per day

5. Caffeinated tea: ☐ Yes ☐ No
If yes, how much: _____ per day

6. Caffeinated soda: ☐ Yes ☐ No
If yes, how much: _____ per day

7. Smoking: ☐ Yes ☐ Quit ☐ Never
If yes, how much: _____ per day

8. Alcohol use: ☐ Yes ☐ No
If yes, how much: _____ per day

9. Recreational drugs: ☐ Yes ☐ No
If yes, how much: _____ per day

10. Exercise: ☐ Yes ☐ No
If yes, how much: _____ per day

11. Sleeping habits:

☐ Sleep alone ☐ Sleep with bed partner
☐ Sleep with pets ☐ Sleep with children (co-sleeping)

Patient Name:_____

**Review of Systems**

Please check all that has occurred over the previous 12 months:

*Constitutional:*

- ☐ Weight gain
- ☐ Weight loss
- ☐ Change in appetite
- ☐ Fatigue

*Allergy-Immunology:*

- ☐ Seasonal allergies
- ☐ Sneezing

*Head-Eyes:*

- ☐ Headaches
- ☐ Change in vision

*Ears-Nose-Throat:*

- ☐ Sinus symptoms
- ☐ Nasal discharge
- ☐ Sore throat
- ☐ Mouth breathing
- ☐ Nasal congestion
- ☐ Nose bleeds
- ☐ Hoarseness
- ☐ Ear pain

*Lungs:*

- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Frequent coughing
- ☐ Chest tightness

*Heart:*

- ☐ Chest pain
- ☐ Heart failure
- ☐ Leg swelling
- ☐ Palpitations
- ☐ Sleep with more than 1 pillow
- ☐ Waking up short of breath at night

*Gastrointestinal:*

- ☐ Reflux
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Abdominal bloating

*Genito-urinary:*

- ☐ Bedwetting
- ☐ Frequent nighttime urination

*Endocrine:*

- ☐ Cold intolerance
- ☐ Heat intolerance

*Musculoskeletal:*

- ☐ Arthritis
- ☐ Chronic pain
- ☐ Fibromyalgia
- ☐ Muscle weakness

*Neurologic:*

- ☐ Seizures
- ☐ Memory problems
- ☐ Stroke
- ☐ Concentration problems

*Psychiatric:*

- ☐ Depressed mood
- ☐ Anxiety about health
- ☐ Claustrophobia
- ☐ Mild worry
- ☐ Generalized anxiety
- ☐ Post-traumatic stress disorder

*Hematologic-Lymphatic:*

- ☐ Anemia
- ☐ Bleeding

*Skin:*

- ☐ Rash
- ☐ Eczema

Patient Name:_____

**Immunization history:**

Please check the immunizations you have had and the date

| | Yes | No | Date |
|---|---|---|---|
| Influenza (annual flu vaccine) | ☐ | ☐ | _____ |
| Pneumovax/PPSV23 (pneumonia vaccine) | ☐ | ☐ | _____ |
| Prevnar 13/PC13 (pneumonia vaccine) | ☐ | ☐ | _____ |
| Tdap (tetanus WITH pertussis/whooping cough vaccine) | ☐ | ☐ | _____ |
| Zostavax (shingles/herpes zoster vaccine) | ☐ | ☐ | _____ |