National Jewish Health

Patient Label

Sleep Center

For office use only	
Appt date:	Clinician:

Main Campus
1400 Jackson Street
Denver, CO 80206

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

DTC Location
7877 South Chester St.
Englewood, CO 80112

303.270.2708
303.270.2109 Fax

Leading respiratory hospital in the nation.

Sleep Center

Sleep 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: ______________________________
Street Address: ______________________________
Phone Number: ______________________________
Referring Physician/PCP______________________________

Date of birth: ____________________
City/State: ____________________
Home   Mobile   Work (circle one)
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______________________________
Address______________________________

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	☐	☐

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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 grinding or clenching	☐	☐

Sleep Schedules	Weekdays		Weekends
1. What time do you get into bed at night?	________		________
2. Do you watch TV, read, use computer, etc 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	☐	☐

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	☐	☐

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17. Post-traumatic stress disorder	☐	☐
18. Attention deficit hyperactivity disorder	☐	☐

19. Any other: ____________________

____

Medical Equipment

If you currently receive medical equipment, what is the name of your equipment company?

____

Are you on oxygen? ☐ Yes ☐ No If so, how much?____________________

Are you on CPAP or BiPAP? ☐ Yes ☐ No If so, what are your settings? ____________________

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

Does 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? ____________________

Medications

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

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

Patient Name: ____________________________________

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

Allergy-Immunology:

- ☐ Seasonal allergies
- ☐ Sneezing

Head-Eyes:

- ☐ Headaches
- ☐ Change in vision

Ears-Nose-Throat:

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

Lungs:

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

Heart:

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

Gastrointestinal:

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

Genito-urinary:

- ☐ Bedwetting
- ☐ Frequent nighttime urination

Endocrine:

- ☐ Cold intolerance
- ☐ Heat intolerance

Musculoskeletal:

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

Neurologic:

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

Psychiatric:

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

Hematologic-Lymphatic:

- ☐ Anemia
- ☐ Bleeding

Skin:

- ☐ Rash
- ☐ Eczema

Patient Name: ___________________________________

Epworth Sleepiness Scale

Name: _____________________________ Date of office visit: _____________

Date of birth: _______________________

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:

Score:
- 0 – Would never doze
- 1 – Slight chance of dozing
- 2 – Moderate chance of dozing
- 3 – High chance of dozing

Situation	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.