National Jewish Health™
Science Transforming Life®

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

For office use only
Appt date: Clinician:

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
7877 South Chester St.
Englewood, CO 80112

303.270.2708
303.270.2109 Fax

Sleep Center New Patient Questionnaire

PRIOR TO SCHEDULING:

1. Patient to submit completed questionnaire. Email: CenterS@njhealth.org or 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.

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:

_____

_____

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	☐	☐
13. Frequent disturbing dreams or nightmares	☐	☐

	Yes	No
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

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: _____
_____

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

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? _____

Medications

Please list current medications:

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:

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)

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

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)	☐	☐	_____

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

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.