

Paul E. Wylie, M.D. / Donna R. Wright, APN
Arkansas Center for Sleep Medicine Initial Evaluation Questionnaire

First Name: _____ Middle Initial _____ Last Name _____

Your Age: _____ Sex: _____ Spouse's or Significant Other's Name: _____

Who referred you or how did you locate our practice? _____

Who is your primary care physician? _____

Who is your medical insurance carrier? _____

PLEASE DESCRIBE BELOW WHAT TYPE OF PROBLEM/S WITH YOUR SLEEP NEED/S TO BE EVALUATED TODAY?

PLEASE CIRCLE THE BEST ANSWER / S BELOW

Have you undergone a previous clinical or research sleep study? Yes No

Have you ever been evaluated or treated by another sleep doctor? Yes No

If yes, please describe below the date, reason, place, doctor's name, and a brief description of your study findings and treatment

Do you snore?	Yes	No	Don't Know	How loud?	Soft	Medium	Loud
How often?	Rarely	Frequently	Always	In what positions?	Sides	Back	Stomach

IMPORTANT: For how many years has any snoring at all been present? _____

Do you frequently awaken from sleep due to / with the following? Yes No Circle Which One Below if Yes:

 Snorts Gasps Choking Gagging Panic Shortness of breath Fast heartbeat

Do you frequently have trouble breathing through your nose in the daytime? Yes No

Do you frequently have trouble breathing through your nose during sleep? Yes No

Has anyone noticed that you seem to pause or stop breathing for periods of time during sleep? Yes No

DESCRIBE BELOW: Who noticed the pauses? Is there a pattern to the pauses? For how long have the pauses been noticed?

Do you frequently experience episodes of excessive daytime sleepiness? Yes No

Do you frequently experience fatigue and low energy? Yes No

DESCRIBE BELOW: When did the sleepiness, fatigue, or low energy first begin? Is the sleepiness, fatigue, and low energy getting progressively worse?
How does sleepiness, fatigue, and low energy affect your life? What do others notice or say about the effect of your sleepiness?

Have you recently gone out of your driving lane due to sleepiness? Yes No

Have you recently had any "close calls", accidents, or other problems due to being drowsy while driving? Yes No

Have you recently had any accidents or problems due to being drowsy while performing your job? Yes No

Do you ever wake up from sleep paralyzed and completely unable to move? Yes No

Do you ever hallucinate when going to or waking up from sleep? Yes No

Do you, **WHILE AWAKE**, have episodes of muscular weakness, to the point where your jaw sags, or your knees buckle, or your neck and shoulders go limp, or your speech becomes slurred, or you can't move in some other fashion? Yes No

If yes, please describe what happens to you below.

Have you been irritable or depressed during this past year? Yes No

Has your memory or concentration changed during this past year? Yes No

Do you feel less interest in or have less energy for activities during this past year? Yes No

What is your current weight measured at home? _____

What is the most you have weighed in the past 5 years? _____

What is the least you have weighed in the past 5 years? _____

Do you currently frequently talk, walk, or have other behaviors during your sleep? Yes No

If yes, please describe below your behavior during sleep.

CIRCLE THE NUMBER below that best indicates on a daily basis what the chance is that you will have to resist falling asleep or will actually fall asleep during each of the following activities?

	SLIGHT	MODERATE	HIGH	(EPWORTH)
Sitting and Reading	1	2	3	
Watching TV	1	2	3	
Sitting inactive in a meeting	1	2	3	
Passenger in a car for an hour	1	2	3	
Lying down to rest in the afternoon	1	2	3	
Sitting quietly after lunch	1	2	3	
Sitting in a car while stopped in traffic	1	2	3	TOTAL _____

Have you ever had trouble breathing immediately after surgery or anesthesia? Yes No

Do you frequently wake with a dry or sore mouth / throat? Yes No

Do you frequently reflux stomach acid into your throat at night? Yes No

Do you frequently experience sweating in the head or neck area during sleep? Yes No

Do you suffer from excessive body sweats during sleep? Yes No

Has your dream frequency or content changed in the past year? Yes No

In the evening, before bedtime, while sitting quietly, are you frequently bothered by an irresistible urge to move your legs? Yes No

As soon as you lay down in bed to try to fall asleep, are you frequently bothered by an irresistible urge to move your legs? Yes No

Has anyone noticed that after you fall asleep your arms or legs twitch or jerk frequently or continuously? Yes No

What time do you generally get into bed at night? _____

Do you regularly read, watch TV, use a computer, or a look at cell phone before going to sleep? Yes No

Does your spouse or partner's sleep behavior interfere with your sleep? Yes No

What time do you usually turn the lights out to actually go to sleep? _____

Does it regularly take you longer than 30 minutes on 3 or more nights a week to fall asleep? Yes No

**Please describe below: What age did you start to have trouble falling asleep? What things or activities seem to make the problem better or worse?
Do you have family members with the same type of problem? How long does it take you to fall asleep without help from medication? How long with medication?**

Do you regularly have trouble on 3 or more nights a week with staying asleep? Yes No

How many times a night do you get out of bed to urinate? _____

When did you first start to have trouble staying asleep? _____

From the list below, please **CIRCLE** what you think might be contributing to you having trouble getting to sleep or staying asleep.

Pain Noise Children Worrying Spouse Phone TV Computer Light Breathing Animals Don't Know

******* Please list below or obtain from your doctor or pharmacist a typed list all names, dosages, and any side effects of all over the counter and prescribed medications that you are currently on and that you've previously have tried specifically for your sleep problem.**

What time do you usually awaken in the morning? _____

What time do you actually get out of bed in the morning? _____

Do you set an alarm? Yes No If yes, for what time? _____

Do you usually awaken feeling refreshed? Yes No

What time of day do you usually leave to go to work? _____

What time of day do you usually get home from work? _____

What time of day might you start to feel sleepy again? _____

Do you take more than 1 nap each week? Yes No

Please describe below:

If you nap, what time of day?	For how long?	Do you dream during naps?	How many naps per week usually?

Does your sleep schedule change on weekends or your days off?	Yes	No	Please describe the change or changes below:

Do you perform shift work? Yes No Straight Rotating Used to but not anymore For how long? _____

Please describe below:

What shifts might you work?	How often do you change shifts?	On days off, when do you sleep?	How long have you been on your current shift?

Do you currently smoke? Yes No

If yes, how many years have you smoked? _____

On average, how many packs a day? _____

Did you previously smoke? Yes No

If yes, for how many years? _____

When did you stop? _____

Do you dip snuff or chew tobacco? Yes No

Do you have bad sinus allergies? Yes No

How many 8oz cans of soda or energy drinks do you consume each day? _____

How many cups of coffee / glasses of tea do you consume each day? _____

If you answered yes to any of the 6 questions above about your blood pressure or heart, please describe below as applicable the date of onset of treatment, the name of the condition, number of events, your treating doctor's name, and any other important circumstances.

Have you ever had a stroke or brain injury?	Yes	No		
Do you have blockage in the carotid arteries of the neck?	Yes	No		
Do you have asthma?	Yes	No		
Do you have emphysema or COPD?	Yes	No		
Do you have pulmonary hypertension in your lungs?	Yes	No		
Do you have diabetes?	Yes	No	Insulin	Non-Insulin

If you answered yes to any of the 6 questions above, please describe below as applicable the date of onset of treatment, type of treatments, your treating doctor's name, and any other important circumstances.

Do you have hypoglycemia?	Yes	No		
Do you or did you have epilepsy or a seizure?	Yes	No		
Do you have stomach ulcers or nighttime gastric reflux?	Yes	No		
Do you currently suffer from clinical depression?	Yes	No		
Are you currently having any suicidal thoughts or plans?	Yes	No		
Do you suffer from an anxiety disorder?			Yes	No
Have you been treated for depression, suicide, or anxiety, in the past 5 years?			Yes	No
Have you been treated for PTSD, Bipolar, Schizophrenia or other mental health issues in the past 5 years?			Yes	No

If you answered yes to any of the 8 questions above, please describe below as applicable the date of onset of treatment, type of treatments, your treating doctor's name, and any other important circumstances.

Have you ever had melanoma skin cancer? Yes No

Have you had any other type of cancer in your body? Yes No

If yes, please describe below the type, location, year of onset, type of treatment, and provide name of the treating doctor.

Do you have Parkinson's disease? Yes No

Do you have a liver or kidney problem? Yes No

Do you have a problem with alcoholism or substance abuse? Yes No

Do you have arthritis or fibromyalgia? Yes No

Do you have back problems? Yes No

Do you have thyroid problems? Yes No

Have you ever had an aneurysm? Yes No

Have you ever had a hysterectomy? Yes No

Have you had both of your ovaries removed? Yes No

Do you have a bladder or back electrical stimulator implant? Yes No

If you answered yes to any of the 10 questions above, please describe below as applicable the date of onset of treatment, type of treatments, your treating doctor's name, and any other important circumstances.

Where were you born? _____

Where have you lived most of your life? _____

What is the highest level of education you have achieved? _____

Did you or do you serve in the military? Yes No

If yes, what branch and for how long? _____

What is your current military job? _____

Engage in Combat? Where? _____

Are you married? Yes No

Do you have children? Yes No How many? _____ How old? _____

How many brothers and sisters do you have? Brothers _____ Sisters _____

What is your current place of employment? _____

What type of work do you currently do there? _____

What type of work have you done in the past? _____

What activities do you do for fun or entertainment? _____

Do any of your genetic family members suffer from any of the medical disorders listed below? If so, please list below which ones are affected.

CIRCLE IF APPLICABLE -- No Information Available -- Adopted

Loud Snoring / Sleep Apnea _____

Sudden Death during Sleep _____

Restless Legs Syndrome _____

Narcolepsy _____

Insomnia _____

Abnormal Sleep Behavior _____

High Blood Pressure _____

Cancer _____

Stroke _____

COPD _____

Coronary Disease or Heart Attack _____

Diabetes _____

Heart Failure or Abnormal Heart Rhythm _____

Pulmonary Hypertension _____

Depression / Anxiety / Suicide _____

Parkinson's disease _____

Alcoholism or Substance Abuse _____

Liver or Kidney Disease _____

Please indicate below the name, phone number, and location of your regular pharmacy.

Do you also use a mail order pharmacy service? Yes No Which one?

What does a bed partner or a sleep observer report about your sleep? Please briefly describe in the space below any reported problems with snoring, breathing, excessive sleepiness, energy, falling asleep, staying asleep, excessive movement, waking up, headaches, irregular sleep schedule, alertness while driving, or abnormal behavior during sleep..

DOCTOR'S NOTES:
