Wesley Neurology Clinic
Marc E. Hofmann, MD, FCCP, FAASM
Adult Initial Questionnaire

Name: _____ Date: _____
Insurance Carrier: _____ Referring Physician: _____
Birth date: _____ Age: _____ Sex: _____
Marital Status (circle): Single_____ Married_____ Divorced_____ Widowed_____
Height: _____ Weight: _____ Neck Size: _____

Reason for visit: _____

General Sleep			
Do you snore?	Yes	No	Describe:
Do you choke in your sleep?	Yes	No	Describe:
Do you gasp in your sleep?	Yes	No	Describe:
Do you stop breathing in your sleep?	Yes	No	Describe:
Do you have difficulty initiating or maintaining sleep?	Yes	No	Describe:
Have you been told that you snore?	Yes	No	Describe:
Have you been told that you choke in your sleep?	Yes	No	Describe:
Have you been told that you gasp in your sleep?	Yes	No	Describe:
Have you been previously diagnosed with sleep apnea?	Yes	No	Describe:
Are you currently on CPAP or Bi-Level therapy?	Yes	No	Describe:
Are you having trouble with CPAP or Bi-Level therapy?	Yes	No	Describe:
If not on CPAP/Bi-Level therapy, why?			
If not on CPAP/Bi-Level therapy, what therapy are you on?			

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Are you bothered by waking up too early and not being able to get back to sleep?	Yes	No	If yes, please describe:	
Do you feel like you get to little sleep at night or during your sleep period?	Yes	No	If yes, please describe:	
Do you feel tired and non-refreshed when you wake up in the morning or after your sleep period?	Yes	No	If yes, please describe:	
How many minutes are you awake before you finally get up?	Minutes:			
On average, how long do you sleep at night or during your sleep period?	Hours:			
Are you bothered by sleepy spells during the day?	Yes	No	If yes, please describe:	
Do you take naps?	Yes	No	If yes, how long: Feel better afterwards? Y N	
Are you bothered by nightmares?	Yes	No	If yes, please describe:	
Are you afraid of going to sleep?	Yes	No	If yes, please describe:	
How long have you had your sleep problem?	Weeks:		Months:	Years:
How long does it take you to fall asleep at night?	Minutes:		Hours:	
How many nights per weeks do you have a sleep problem?	Nights/week:			
What time do you usually go to bed?	AM:		PM:	
What time do you usually get up?	AM:		PM:	
On average, how many times do you wake up during the night or during you sleep period?	Times/night:			
Why do you wake?	Describe:			

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Have you ever been told or are you aware of having unusual behavior or activity during sleep such as?			
Muscle twitches	Yes	No	If yes describe:
Leg discomfort	Yes	No	If yes describe:
Leg kicking	Yes	No	If yes describe:
Acting out of dreams	Yes	No	If yes describe:
Yelling out	Yes	No	If yes describe:
Punching	Yes	No	If yes describe:
Violent behavior	Yes	No	If yes describe:

When sitting quietly for prolonged periods or when lying down to go to sleep (just prior to falling asleep) do you suffer from:			
A desire to move the limbs, often associated with abnormal sensations or movements?	Yes	No	If yes describe:
Symptoms that are worse or present only during rest and are partially or temporarily relieved by activity?	Yes	No	If yes describe:
Motor restlessness?	Yes	No	If yes describe:
Nighttime worsening of symptoms?	Yes	No	If yes describe:

Have you ever fallen asleep while at a stoplight or driving?	Yes	No	If yes, describe:
Have you ever fallen asleep at inappropriate times? I.e. during a conversation?	Yes	No	If yes, describe:
Have you ever fallen asleep or have generalized weakness while laughing, hearing or telling a joke of if upset?	Yes	No	If yes, describe:
Do you have vivid dreams upon falling asleep or awakening from sleep?	Yes	No	If yes, describe:
Have you ever had periods of immobility upon awakening from sleep?	Yes	No	If yes, describe:

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Do you engage in activities that keep you from falling asleep at night, such as?		
Watching TV?	Yes	No
Computer usage?	Yes	No
Listening to music?	Yes	No
Reading?	Yes	No
Smoking?	Yes	No
Alcohol consumption?	Yes	No
Excessive caffeine intake?	Yes	No
Excessive eating/drinking?	Yes	No

Do you:		
Stick to a sleep schedule?	Yes	No
Get enough morning daylight?	Yes	No
Exercise regularly?	Yes	No
Avoid daytime napping?	Yes	No
Avoid post-lunchtime caffeine?	Yes	No
Avoid nighttime nicotine?	Yes	No
Wind down before bedtime?	Yes	No
Keep bedroom cool, quiet, dark, comfortable?	Yes	No

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Does your mind race when you lay down to fall asleep?	Yes	No		
Do you clock watch if unable to fall asleep?	Yes	No		
What do you do or use to help you fall asleep?				
Have you gained weight recently?	Yes	No		
Are you aware of anything that disturbs your sleep such as indigestion, noise, pain, heart problems?	Yes	No	If yes, please describe:	
Do wake up with any of the following?	Headache	Yes	No	
	Dry mouth	Yes	No	
	Sore throat	Yes	No	
Are you under any stress or feel depressed or anxious?	Yes	No	If yes, please describe:	

Do you have chronic nasal congestion?	Yes	No	
Do you have difficulty breathing through your nose?	Yes	No	
Have you had any trauma to your nose?	Yes	No	
Have you ever been told that you have a small airway?	Yes	No	
Have you ever been told that you have a deviated septum?	Yes	No	
Have you ever been told that you have enlarged tonsils?	Yes	No	
Do you still have your tonsils?	Yes	No	

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Medical History (Circle)							
Chronic bronchitis or cough	Asthma	COPD/emphysema	Diabetes	Cholesterol	Stroke	Sleep walking	Parkinson's disease
Hyperthyroidism	Hypothyroidism	Heart disease	Cerebral palsy	Cancer	Autoimmune disease	Sleep talking	Dementia
Rhinitis/sinusitis	Seizures	Sleep apnea	ESRD	Migraine/chronic headaches	Depression	Nightmares	Vision problems
Anxiety	Bipolar disorder	Chronic pain	GERD	Narcolepsy	Insomnia	Obesity	Hearing problems
Suicide attempt	Psychiatric admission	Chromosomal abnormalities (Down's)	Throat infections	Hypertension	Myocardial infarction	CHF	Coronary artery disease
Other:							

Surgical History (Circle)					
Tonsillectomy	Adenoidectomy	Nasal septal surgery	Sinus surgery	Tracheostomy	Head or neck trauma
Uvulopalatopharyngoplasty (UPPP)	Coronary artery bypass	Cardiac stent			
Other:					

Social History			
Tobacco:	Packs/day:	How long:	Quit when:
Alcohol:	How much:	How long:	Quit when:
Natural coffee:	Cups/day:	Decaf:	Cups/day:
Caffeinated carbonated soft drinks:	Cans/glasses/day:	Decaf carbonated soft drinks:	Cans/glasses/day:
Social drug use (cocaine, heroin, marijuana, methamphetamine etc.):	How much:	How long:	Quit when:

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Medication History			
Name	Dose	Frequency	Reason

Allergy History
Seasonal allergies:
Medication allergies:

Family History (Circle)

Coronary artery disease	Myocardial infarction	Stroke	Hypertension	Diabetes	Asthma
COPD/emphysema	Glaucoma	Kidney disease	Liver disease	Blood clots	Cancer
Sleep apnea	Narcolepsy	Insomnia	Restless legs syndrome	Periodic limb movement disorder	Snoring
Thyroid disorder	Sleep Walking	Sleep talking			
Other:					

Occupational History			
Do you work?	Yes	No	Job description?
What shift?			
What hours?			

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would affect you.

Use the following scale to choose the ***MOST APPROPRIATE*** number for each situation:

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0 = would ***NEVER*** doze
1 = ***SLIGHT*** chance of dozing
2 = ***MODERATE*** chance of dozing
3 = ***HIGH*** Chance of dozing

Situation	**Chance of dozing**
Sitting and reading?	
Watching TV?	
Sitting, inactive in a public place (e.g. a theater or a meeting)?	
As a passenger in a car for an hour without a break?	
Lying down to rest in the afternoon when circumstances permit?	
Sitting and talking to someone?	
Sitting quietly after a lunch (without alcohol)?	
In a car, while stopped for a few minutes in traffic?	
Total:	

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Answer the questions to determine if you are at risk for Obstructive Sleep Apnea:

		Yes	No
S (snoring)	Do you snore loudly?		
T (tired)	Do you often feel tired, fatigued or sleepy during the day?		
O (observed)	Has anyone observed you stop breathing during your sleep?		
P (blood pressure)	Do you have or are you being treated for high blood pressure?		
B (BMI)	BMI >35?		
A (age)	Age >50?		
N (neck)	Neck circumference >16 in?		
G (Gender)	Male?		

High risk of OSA: answering yes to >3 or more items.
Low risk of OSA: answering yes to <3 items.

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On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out of the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY. Circle the number beside the statement you picked. Several statements in the group may seem to apply equally well. If so, then circle the number beside each statement. Be sure to read all the statements in each group before making your choice.

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and can't snap out of it.
   3. I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1. I feel discouraged about the future.
   2. I feel I have nothing to look forward to.
   3. I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1. I feel I have failed more than the average person.
   2. As I look back on my life, all I can see is a lot of failures.
   3. I feel I am a complete failure.

4. 0 I get as much satisfaction out of things that I used to.
   1. I don't enjoy things the way I used to.
   2. I don't get real satisfaction out of anything anymore.
   3. I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1. I feel guilty a good part of the time.
   2. I feel quite guilty most of the time.
   3. I feel guilty all the time.

6. 0 I don't feel I am being punished.
   1. I feel I may be punished.
   2. I expect to be punished.
   1. I feel I am being punished.
   3.

7. 0 I don't feel disappointed in myself.
   1. I am disappointed in myself.
   2. I am disgusted with myself.
   3. I hate myself.

8. 0 I don't feel I am any worse than anybody else.
   1. I am critical of myself for my weaknesses or mistakes.
   2. I blame myself all the time for my faults.
   3. I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1. I have thoughts of killing myself, but I would not carry them out.
   2. I would like to kill myself.
   3. I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
    1. I cry more now than I used to.
    2. I cry all the time now.
    3. I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated now than I ever am.
    1. I get annoyed or irritated more easily than I used to
    2. I feel irritated all the time.
    3. I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
    1. I am less interested in other people than I used to be.
    2. I have lost most of my interest in other people.
    3. I have lost all my interest in other people.

13. 0 I make decisions about as well as I ever could.
    2. I put off making decisions more than I used to.
    3. I have greater difficulty in making decisions than before.
    4. I can't make decisions at all anymore.

14. 0 I don't feel I look any worse than I used to.
    1. I am worried that I am looking old or unattractive.
    2. I feel that there are permanent changes in my appearance that make me look unattractive.
    3. I believe that I look ugly.

15. 0 I can work about as well as before.
    1. It takes an extra effort to get started at doing something.
    2. I must push myself very hard to do anything.
    3. I can't do any work at all.

16. 0 I can sleep as well as usual.
    1. I don't sleep as well as I used to.
    2. I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3. I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get any more tired than usual.
    1. I get tired more easily than I used to.
    2. I get tired from doing almost anything.
    3. I am too tired to do anything.

18. 0 My appetite is no worse than usual.
    1. My appetite is not as good as it used to be.
    2. My appetite is much worse now.
    3. I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
    1. I have lost more than 5 pounds.
    2. I have lost more than 10 pounds.
    3. I have lost more than 15 pounds.

    I am purposely trying to lose weight by eating less? Y or N

20. 0 I am no more worried about my health than usual.
    1. I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
    2. I am very worried about physical problems and it's hard to think of much else.
    3. I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
    1. I am less interested in sex as I used to be.
    2. I am much less interested in sex now.
    3. I have lost interest in sex completely.

Total: _____