Neurodiagnostic Sleep Lab- Intake Questionnaire

Patient Information

Today's Date: _____

Last Name_____First Name_____Middle Initial_____

Address_____City_____ State: _____Zip: _____

Date of Birth_____ Age _____ ☐Male ☐Female

Height_____feet _____ inches Weight_____lbs. Neck Size _____inches

Email Address_____

☐Cellular Phone_____ ☐Home Phone_____ ☐Work Phone_____

Please check preferred contact #

Occupation _____Married: ☐Yes ☐No

Referring Physician Name_____

Please describe the main problem which brings you to this Sleep Center:

_____

_____

_____

How long have you been experiencing this problem? _____

If you've received treatment for this problem, please explain:

_____

Describe your bedtime routine: _____

Do you have trouble falling asleep? ☐Yes ☐No How long does it take you to fall asleep? _____

How many hours of sleep do you get each night? _____

Bedtime on weekdays: _____ weekends: _____

Wake up time on weekdays: _____ weekends: _____

Frequency of night awakenings: _____ How long do you stay awake? _____

If you wake up, what do you do during night awakenings? _____

Do you use any electronics in bed (TV, smart phone, computer, tablet etc.)? ☐Yes ☐No If yes, length of time_____

Do you take naps? ☐Yes ☐No If yes, how long_____ and how often _____

Patient Label

Please check how often you:	Never	Rarely	Sometimes	Frequently	Constantly
Suddenly wake up gasping for breath					
Do you snore					
Awaken at night with heart burn and/or belching					
Awaken at night with coughing or wheezing					
Feel refreshed upon awakening					
Experience excessive daytime sleepiness					
Feel fatigued or low energy level					
Fall asleep during physical activity					
Fall asleep when laughing or crying					
Experience muscle weakness when extremely emotional (ex. laughing or crying)					
Feel unable to move (paralyzed) when waking up or falling asleep					
Experience vivid dreamlike scenes upon waking up or falling asleep					
Notice your heart pounding or beating irregularly during sleep					
Experience recurrent nightmares					
Kick or thrash about during the night					
Experience restless leg symptoms					
Grind your teeth during sleep					
Sleep walking or sleep talking					
Act out your Dreams					
Wake up with a headache					
Wake up with a dry mouth					
Wake up feeling congested					

Patient Label

Check any of the following conditions you have been treated for:

☐Bronchitis	☐Emphysema	☐Chronic Obstructive Pulmonary Disease (COPD)
☐Heart Disease	☐Congestive Heart Failure (CHF)	☐Seasonal Allergies
☐Heart Attack	☐Diabetes	☐Anxiety Disorders
☐High Cholesterol	☐Depression	☐Headaches/migraines
☐Stroke	☐Obesity	☐Asthma
☐High Blood Pressure	☐Abnormal Heart Rhythm	☐None
☐Other: please indicate	☐Other: please indicate	☐Other: please indicate

Please list any other major medical problems, surgeries and/or hospitalizations.

_____

_____

_____

Social history

Have you ever used tobacco products? ☐ Yes ☐ No

If yes, specify type _____ How many years:_____ How much per day:_____

Quit date (if applicable) _____

Do you consume alcoholic beverages? ☐ Yes ☐ No

If yes, how many per day _____ How many per week _____

Do you consume caffeinated beverages? ☐ Yes ☐ No

If yes, how many per day _____ How many per week _____

Do you use any recreational drugs? ☐ Yes ☐No Specify_____

Family history— Check the box below if any blood relative has suffered from the following conditions.

☐Heart Disease	☐High Blood Pressure	☐ Chronic Obstructive Pulmonary Disease (COPD)
☐Stroke	☐Obesity	☐Obstructive Sleep Apnea
☐Narcolepsy	☐Excessive Sleepiness or Fatigue	☐Anxiety Disorders
☐Diabetes	☐Depression	☐Night Terrors
☐Cancer	☐Parkinson's	☐Sleep Walking
☐	☐	☐

_____ _____ _____ _____

Patient Signature | Print Name | Date | Time

_____ _____ _____ _____

Legally Authorized Person Signature | Print Name / Relationship | Date | Time

_____ OR ☐Phone ☐Video _____ _____ _____

Qualified Staff/Interpreter Signature (Check) | Print Qualified Staff/ Interpreter Name | ID Number | Language Interpreter

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Patient Label