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Sleep Patient Questionnaire

Date of Service: _____ Time: _____ am / pm (office use: time _____)

Please provide 24 hour cancellation notice to avoid charges for missed appointments.

Where appropriate, please have an observer of your problem help you complete this prior to your appointment.

Name: _____ Birthdate: _____ Age: _____ Handedness: R L Both Gender: _____

Referring provider (a copy will be sent): _____

If self referred, do you have a primary physician? _____

Copies of this evaluation to other providers? _____

Very briefly, what is the main problem & when it began?

Are you naturally more of a "morning lark", "night owl" or neither? Does this change with the seasons? No Yes

Do you shift work? No Yes Work schedule: _____

Do you travel across time zones? No Yes How far & how often? _____

In bed: school/work nights: Earliest _____ Latest _____ Nights off: Earliest _____ Latest _____

In bed, do you: Read / Write / Watch TV / Listen to the radio / Use a computer / Check the time

Lights out: Work / School nights: Earliest _____ Latest _____ Nights off: Earliest _____ Latest _____

Do you have insomnia (difficulty sleeping despite given the opportunity)? No If yes, when did this begin?

Do you have difficulty falling asleep beyond 30 min. (sleep onset)? No If yes, how many nights/week?

How long does it take you to fall asleep?

Do you have difficulty staying asleep (sleep maintenance)? No If yes, how many nights/week?

Do you set an alarm? No If yes, what days & times? Someone wakes me I awaken on my own

Rise times: Work / School days: Earliest _____ Latest _____ Days off: Earliest _____ Latest _____

Do you awake refreshed? Yes If no, how long to feel alert?

How often & long do you nap? Are they refreshing? Yes No

Have you ever been totally paralyzed while you were half awake & asleep? No If yes, when did this begin?

Have you ever seen or heard things that weren't real while you were half awake & asleep? No If yes, when did this begin?

Have you ever been completely awake & suddenly become limp in all or part of your body? No If yes, when did this begin?
Was this brought on by strong emotion, such as laughter, anger? No Yes

Do you have sleepiness during your major wake period? No If yes, when did this begin?

Do you fall asleep against your will? (uncontrollable sleep attacks) No If yes, when did this begin?

Chance of dozing off in these situations (If you have not done these recently, imagine how you would be)	Never	Slight	Moderate	High
Sitting & reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place	0	1	2	3
Car passenger for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting & talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
Stopped in a car in traffic for a few minutes	0	1	2	3

Do you have fatigue (low energy)? No If yes, when did this begin?

During the past week, I found that :	Disagree							Agree
My motivation is lower when I am fatigued.	1	2	3	4	5	6	7	
Exercise brings on my fatigue.	1	2	3	4	5	6	7	
I am easily fatigued.	1	2	3	4	5	6	7	
Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7	
Fatigue causes frequent problems for me.	1	2	3	4	5	6	7	
My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7	
Fatigue interferes with carrying out certain duties & responsibilities.	1	2	3	4	5	6	7	
Fatigue is among my 3 most disabling symptoms.	1	2	3	4	5	6	7	
Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7	

Has anyone witnessed you to snore? No If yes, when did this begin?

Has anyone witness you to stop breathing during sleep (apnea)? No If yes, when did this begin?

Do you have difficulty with nasal breathing? No If yes, is it year round or seasonal?

Do you have environmental allergies? No If yes, to what?

Waking up gasping, choking, with or without gastric reflux? No If yes, when did this begin?

Have you had nasal trauma? No If yes, when? Have you had nasal or sinus surgery? No If yes, when?

Have you had your tonsils / adenoids removed? No If yes, when?

Have you significantly gained or lost weight? No If yes, how much & over what time?
Height? Current weight? Maximum weight & when?

Do you have an irresistible need to move your arms or legs? No If yes, when did this begin & describe:

Has a bed partner witness you to kick or jerk in your sleep? No If yes, when did this begin & describe:

Does pain interfere with your sleep? No If yes, describe & rate below:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Constant Maximal Pain
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Do you have numbness / tingling & / or muscle weakness (decreased strength)? No Yes

Do you have problems with thinking, attention, concentration, memory? No Yes

Depression? No If yes, when did this begin & rate below? Is it seasonal? No Yes

Normal Mood	0	1	2	3	4	5	6	7	8	9	10	Suicide precautions
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Anxiety / Panic? No If yes, when did this begin & rate below?

Sustained Calm	0	1	2	3	4	5	6	7	8	9	10	Sustained panic
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Irritability / Hypomania / Mania / Obsessive-Compulsive Behavior? No If yes, when did this begin?

DRUG ALLERGIES:				
HABITS: (how much, how often, how late in the day, history of abuse and last use)				
Caffeine				
Alcohol				
Tobacco				
Illicit Drugs				
MEDICATIONS: (including over-the-counter and herbal, if necessary attached separate sheet)				
Current Medications	Purpose	Dosage	Times taken	Side effects
Past Medications				
PAST MEDICAL & SURGICAL HISTORY: (Note problem & onset)				
Hypertension		Brain/Nerves (e.g., concussion, stroke)		
Heart		Psychiatric		
Lung (e.g., asthma)		Arthritis		
Infectious (e.g., hepatitis)		Thyroid		
Kidney		Diabetes		
GI (e.g., GERD, ulcers)		Others:		
Blood (e.g., anemia)		Last blood work:		
FAMILY MEDICAL HISTORY: (blood relatives, especially parents, siblings, children, ages)				Family Member
Sleep Disorders (e.g., sleep apnea, insomnia, RLS, narcolepsy):				
Psychiatric (e.g., depression, anxiety):				
Atherosclerosis (e.g., heart attacks, stroke):				
Endocrine (e.g., thyroid, diabetes):				
Neurologic (e.g., Parkinson's)				
Other:				
SOCIO-ECONOMIC HISTORY:				
Education:				
Occupation:				
Marital Status:				
Housing:				
REVIEW OF SYSTEMS: (check all boxes that apply)				
Appetite: Increased / Decreased		Difficulty urinating		
Shortness of breath		Urine incontinence		
Coughing		Bowel incontinence		
Palpitations		Sexual dysfunction		
Foot / leg swelling		Bruising / bleeding		
Chest pain		Cold / heat intolerance, hot flashes, sweats, fever		
Rashes		Last menstrual period:		
Joint pain, tenderness, swelling		Other:		

Additional Comments: