DuPage Medical Group
Pulmonary and Sleep Medicine
Patient Questionnaire

Patient Name: ____ Date: __________________

Age: _________ Sex: ______ Height: ____________ Weight: __________ Neck Size: __________

1. Briefly describe your sleep complaint: ____

____

2. How long have you had this problem? ____
3. What is your usual bedtime? _________ AM/PM

   What is your usual wake time? _______ AM/PM
4. How long does it usually take you to fall asleep? ________ Hours ________ minutes
5. How many times do you wake up during the night? ______
6. Do you usually feel refreshed when you wake up in the morning? □ Yes □ No
7. Do you take PLANNED naps? □ NEVER □ DAILY □ WEEKLY
8. Do you DOZE OFF UNINTENTIONALLY? □ NEVER □ DAILY □ WEEKLY

Review of Systems

The following questions pertain to symptoms you may experience JUST PRIOR TO FALLING ASLEEP, DURING SLEEP, or UPON AWAKENING. How often do you:

	Never		Monthly		Nightly
9. just prior to falling asleep or upon awakening, experience cramping or aching leg feeling and inability to keep legs still	1	2	3	4	5
10. experience leg jerks while you are asleep	1	2	3	4	5
11. snore	1	2	3	4	5
12. hold your breath or stop breathing while asleep..	1	2	3	4	5
13. have nasal congestion	1	2	3	4	5
14. breathe through your mouth while you are asleep	1	2	3	4	5
15. have restless, disturbed sleep	1	2	3	4	5
16. just prior to falling asleep or right after waking up, experience vivid, dream like scenes even though you knew that you were awake	1	2	3	4	5
17. experience weakness or paralysis (just before falling asleep or upon awakening)	1	2	3	4	5
18. DURING THE DAY experience sudden muscle Weakness and or fallen, but did not lose consciousness	1	2	3	4	5

Social History

19. How many caffeinated beverages do you drink per day? _______ Per week? _____
20. How many alcoholic beverages do you drink per day? ______ Per week? ______

21. Have you ever smoked? Y / N If so, how much tobacco did you use? _____ Cigarettes per day

22. What is Your Current Occupation?________________________ Are You Exposed to Fumes/Dust?______________

EPWORTH SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things during the past week, estimate how likely you would be to doze off or fall asleep in these situations. Use the following scale:

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

Situation	Chance of Dozing
a) Sitting and reading	_____
b) Watching TV	_____
c) Sitting, inactive in a public place (e.g., a theatre or a meeting	_____
d) As a passenger in a car for an hour without a break	_____
e) Lying down to rest in the afternoon when circumstances permit	_____
f) Sitting and talking to someone	_____
g) Sitting quietly after a lunch without alcohol	_____
h) In a car, while stopped for a few minutes in traffic	_____
23. Total	_____

24. List all MEDICAL and PSYCHIATRIC problems for which you have been or are currently being treated: ____

____

____

25. List all past SURGICAL procedures ____

____

____

26. List all prescriptions and over the counter medications you are taking:

Medication	Dose	Medication	Dose

27. Are you allergic to any medications? Please list______________________________________

____

Family Medical History

28. Please provide information about the ***medical problems*** of your relatives:

Father_________________ Mother _________________ Sibling(s) __________________

REVIEW OF SYSTEMS

Y	N		Y	N	
		Fever or chills			Bone, muscle or joint problems
		Weight loss			Depression, anxiety or mental illness
		Sweats			Skin conditions, growths or cancers
		Fatigue			Allergy or immune problems
		Visual problems			Kidney, bladder or urination problems
		Asthma, breathing or lung problems			Sexual, gynecologic, or testicular problems
		Chest pain			Seizure
		Heart problems (heart attack, pacemaker…)			Thyroid, endocrine or hormone disorders
		Stroke or headache problems			Tuberculosis or infectious disease
		Blood pressure or circulation problems			HIV or AIDS
		Blood or lymph nodes diseases			Hepatitis A, B or C
		Excessive or abnormal bleeding			Excessive scarring
		Stomach or digestive problems (ulcer, heartburn …)			Recent dental work
		Sleep or snoring problems			Do you have any other conditions or problems

Review of systems otherwise negative ☐

Please explain if you answered yes to any of the above: ________________________________

____

____

Other Problems? Please list:

____

____

____

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____

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____

____

Completed by: (Patient Signature) ____

Physician Signature: ____