Desert Pulmonary & Sleep Consultants, PLC

Patient Questionnaire for Sleep Disorders Evaluation

Name:_____ DOB:_____/_____/_____ Today's Date ____/____/_____

Please answer the following questions and requested information the best you can. This is to assist the doctor in evaluating your problems and also serve as a reminder of questions you might like to ask. Thank you.

I. MAIN SLEEP PROBLEM: _____

II. MEDICAL HISTORY (Check yes or no; if yes please describe)

	YES	NO	DESCRIPTION
Arthritis			
Atrial Fibrillation			
Asthma			
Back problems			
Congestive Heart Failure			
Diabetes			
Depression			
Heart disease			
High blood pressure			
Restless leg syndrome			
Sleep apnea			
Stroke			
Thyroid disease			
Urinary problems			
Other			

III. SURGICAL HISTORY (Check yes or no, year of procedure and description

	YES	NO	YEAR	DESCRIPTION
Adenoids				
Tonsils				
Thyroid				
Back				
Nose				
Jaw				
Lung				
Heart				
Other				

IV. FAMILY HISTORY (Have any blood relatives had any of the following? Check yes or no and list the family member)

	YES	NO	FAMILY MEMBER
Sleep apnea			
Narcolepsy			
Sleep problems			
Thyroid disease			
Obesity			

	YES	NO	FAMILY MEMBER
Heart disease			
High blood pressure			
Snoring			
Stroke			
Other			

Race _____ Language _____ Ethnicity _____ I prefer not to complete this section ☐

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V. CURRENT MEDICATIONS

MEDICATION	DOSAGE
PHARMACY NAME:	**FAX/PHONE:**

VI. MEDICATION ALLERGIES (Please list all drug allergies)

MEDICATION/DRUG	REACTION(S)

V. IMMUNIZATION HISTORY (Indicate year received immunization)

	YEAR		YEAR
BCG		Tetanus	
Flu		Other	
Pneumonia			

VII. SMOKING HISTORY (Check all that apply)

	YEAR STARTED	LAST YEAR USED	USAGE PER DAY?
Cigarettes			
Cigars			
Pipe			
Chewing Tobacco			
Marijuana/Other			

VIII. CAFFEINE/ALCOHOL HISTORY

	AMOUNT PER DAY		AMOUNT PER DAY
Coffee		Energy Drinks	
Tea		Beer/Wine	
Soft Drinks		Liquor/Mixed Drinks	

IX. HEIGHT/WEIGHT HISTORY

My Usual Weight is:		pounds
Maximum Weight Attained		pounds

My Ideal Weight:		pounds
My Height		inches

X. SOCIAL HISTORY

MARITAL STATUS		AGES OF CHILDREN	M	F		Y	N
Married/Partnered					Exposure to Asbestos?		
Divorced/Separated					Exposure to smoke or chemical fumes?		
Widow(er)					Shift Work?		
Single					**OCCUPATION:**		