

Patient Questionnaire

Today's Date: _____

Name: _____

Who referred you here? _____

Age: _____ Marital Status: S/M/D/W/Partnered Dominant Hand: R/L Height: _____ Weight: _____

Occupation: _____ What shift do you usually work?: _____

What is the main reason you are here today? _____

Have you ever almost fallen asleep while driving? Yes No

Do you work nights or rotating shifts? Yes No

Do you have (or have you been told by others) that any of the following occur in your sleep:

Snoring	Yes	No	Sleepwalking	Yes	No
Apnea (stop breathing)	Yes	No	Bedwetting	Yes	No
Gaspings, choking, snort	Yes	No	Grinding of the teeth	Yes	No
Leg jerks/twitches	Yes	No	Difficulty falling asleep	Yes	No
Violent or strange behavior	Yes	No	Difficulty staying asleep	Yes	No
Act out dreams/nightmares	Yes	No	Difficulty getting up in AM	Yes	No

How **long** have the above issues been going on? <1 year 1 to 5 years 5-10 years >10 years

What **time** do you get into bed: _____ How long does it take you to fall asleep? _____ minutes

What **time** to you get up in the AM _____

Do you feel **refreshed** in the morning? Yes No

Do you ever wake up with a **morning headache**? Yes No

Do you ever wake up with a **dry mouth**? Yes No

Can your bed partner **still sleep in the same room** as you? Yes No

How many **pillows** do you use to sleep? _____

Do you typically **watch TV, read, worry, or eat** while in bed? Yes No

Is your bedroom **comfortable** (sounds, partner, animals)? Yes No

Have you ever **fractured your nose** or jaw? Yes No

How much **caffeine** do you drink per day? _____

How much **alcohol** do you drink per day? _____

Do you ever use **alcohol** to help you relax in order to fall asleep? Yes No

How much **nicotine** (cigarettes, cigars, chewing tobacco) do you use per day? _____

How many years have you smoked or chewed? _____

Do you now use marijuana, cocaine, meth, ecstasy, heroin, hallucinogens? Circle the "Yes" answers

Have you used marijuana, cocaine, meth, ecstasy, hallucinogens, etc? Circle the "Yes" answers

Have you had any prior **chemical dependency treatments**? Yes No Where? _____

Is a **Psychologist** or therapist or counselor treating you now? Yes No Who? _____

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Circle your current mood: Depressed Anxious Panic Irritable Agitated Flat Manic Hypomanic

Any **suicide attempts** in the past? Yes No If yes, when and how _____

Any **self injurious behaviors** in the past (such as cutting yourself)? Yes No

Any **psychiatric hospitalizations** in the past? Yes No When/Where? _____

Have you had Electroconvulsive Therapy (ECT)? Yes No Where/when _____

Have you been ever been diagnosed or had symptoms of **Anorexia or Bulimia Nervosa**? Yes No

If overweight now, what **diets or prescription medications** have you tried? _____

Have you had any prior **Sleep Studies**? Yes No Where/when? _____

Current Stressors: _____

What psychiatric and/or sleep medications that you have attempted in the past:

Past Medical History: List any medical problems you have had or have currently.

Past Surgical History: List any surgical procedures you have had.

Prior Anesthesia Complications? _____

Any know allergies to medications, tape, foods, dogs, cats?

Current Medications: List your current medications, dosages and how frequently you take them:

Over the counter supplements/vitamins: _____

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Brief Social History:

Born in what city: _____ Raised in what city? _____
How many brothers do you have? __ How many sisters do you have? __ What number child are you __?
Current Marital Status: Married/Single/Divorced/Widowed/Partnered How long? _____
Please list the age and sex of your children: _____
Current Living Situation: Multi-level house, One level house, Condominium, Apartment, GroupHome
Spouse/Partner: Age: ____ Occupation: _____
Who do you live with/who helps take care of you? _____

Any **abuse issues** in your past (Emotional, Verbal, Physical or Sexual)? Yes No
Who/When? _____

Any **family members with a sleep disorder** that you know of? If so who and what disorder?

Any **family member with a psychiatric disorder** that you know of? If so who and what disorder?

Any **family members with chemical dependency** problems? If so who and what substances?

Education: High School Name: _____ Graduate? Yes/No/GED
College Name: _____ Graduate? Yes/No
Major: _____
Graduate School: _____ Graduate? Yes/No
Major: _____

Military History: Yes No Branch: _____ Rank: _____

Legal Problems: Yes No _____

Mother: Age _____ Health Problems: _____

Father: Age: _____ Health Problems: _____

Thank you! An assistant will escort you to one of our examination rooms for vital signs. While you are waiting, bottled water and complementary unsecure Wi-Fi are available. If there is anything we can do to make your brief visit here more enjoyable, please don't hesitate to let us know.

Michael G. Saribalas, D.O., C.B.S.M.

