

Patient Questionnaire

Welcome! Please take a few minutes to complete this questionnaire (not all questions pertain to everyone, but please attempt to answer most questions).

Today's Date: _____

Name: _____

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

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

How can we assist you (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
Gasping , 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 use marijuana, cocaine, meth, ecstasy, hallucinogens, etc? Yes No

Have you used marijuana, cocaine, meth, ecstasy, hallucinogens, etc?

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

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

Patient Questionnaire
Page 2

Circle your moods: Depressed Anxious Panic Irritable Agitated Flat Bland Manic Hypomanic
Any **suicide attempts** in the past? Yes No
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 been ever been diagnosed or had symptoms of **Anorexia or Bulimia Nervosa**? Yes No
If overweight now, what **diets, OTC or prescription medications** have you tried? _____

Have you had any prior **Overnight Sleep Studies**? Yes No Where/what yr? _____

Current Stressors: _____

Psychiatric 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.

Any Prior Anesthesia Problems/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 or vitamins: _____

Patient Questionnaire
Page 3

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 alleged **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: _____
Major: _____

Military History: Yes No Branch: _____ Rank: _____

Legal Problems: Yes No _____

Mother: Age _____ Health Problems: _____

Father: Age: _____ Health Problems: _____

Thank you! An RN or Medical Assistant will escort you to one of our examination rooms. While you are waiting, bottled water and complementary unsecure Wi-Fi are available in the lobby. 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.