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
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 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.