



FOR OFFICE USE ONLY
PT MRN: _____
PROVIDER: _____

Sleep Center
303.270.2708
303.270.2109 Fax

Main Campus
1400 Jackson Street
Denver, CO 80206

Highlands Ranch Location
8671 S. Quebec St., Ste 120
Highlands Ranch, CO 80130

#1 respiratory hospital in the U.S.
US News & World Report

Sleep Center Questionnaire – Please print clearly

PRIOR TO SCHEDULING: If required by your insurance, an authorization and/or referral needs to be sent to National Jewish Health Sleep Center. Please have this faxed to 303.270.2109.

Patient Name: _____

Primary Insurance: _____ Date of birth: _____

Please describe the reason for your visit and chief complaint/s: _____

YES	NO	SLEEP HISTORY
		Have you had a previous sleep study? IF YES, WE NEED ANY PRIOR SLEEP STUDY RECORDS IN ORDER TO PROVIDE ANY NEW TESTING AND CARE OPTIONS. When? _____ Name of facility: _____
		Do you have a diagnosis of Sleep Apnea?
		Are you on a PAP therapy device? If so, what are your settings? _____ Please bring your PAP equipment to each Sleep Clinic appointment including mask and tubing
		Are you on oxygen? If so, how much? _____

If you currently receive medical equipment, what is the name of your equipment company?

How likely are you to doze off or fall asleep in the following situations?

This refers to your usual way of life in **recent times**. If you have not done some of these things recently, try to estimate how they might have affected you. Use the following scale to rate your chance of dozing in the following situations:

0 – Never 1 – Slight chance 2 – Moderate chance 3 – High chance

SITUATIONS	SCORE
Sitting and reading	
Watching TV	
Sitting, inactive, in a public place	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL SCORE	

Reference: Johns MW. A new method for measuring daytime sleepiness: the Epworth sleepiness scale. Sleep. 1991 Dec;14(6):540-5.

MEDICATIONS/ALLERGIES

PLEASE BRING A LIST OF ALL CURRENT MEDICATIONS AND DOSAGES AND ANY DRUG AND MEDICATION ALLERGIES (Current National Jewish Health patients may skip).

Please list medications you have taken for your sleep problem: _____

Patient Name: _____

YES	NO	CURRENT SLEEP SYMPTOMS – PLEASE CHECK ALL THAT APPLY
		Excessive daytime sleepiness
		Drowsy driving
		Have you had a recent accident or near miss due to drowsiness
		Insomnia (difficulty falling asleep or staying asleep)
		Frequent snoring
		Wake up gasping, choking, or feeling short of breath
		Witnessed apneas (breath holding during sleep)
		Excessive sweating during sleep
		Nighttime heartburn
		Headaches upon awakening
		Unpleasant sensations in your legs at night or at bedtime
		Twitching or jerking of your legs during sleep
		Frequent disturbing dreams or nightmares
		Unusual movements or behavior during sleep
		Sleepwalking
		Losing muscle strength when laughing, excited, or angry
		Imagine seeing or hearing things as you fall asleep or wake up
		Feeling unable to move (paralyzed) as you fall asleep or wake up
		Teeth clenching/grinding

YES	NO	MEDICAL, NEUROLOGICAL, OR PSYCHIATRIC HISTORY
		Hypertension
		Heart Failure
		Abnormal cardiac rhythm
		Heart attack
		Asthma
		Chronic obstructive pulmonary disease
		Reflux
		Diabetes
		Thyroid disorder
		Stroke
		Seizures
		Parkinson's disease
		Dementia
		Head trauma
		Depression
		Anxiety disorder
		Post-traumatic stress disorder
		Attention deficit hyperactivity disorder
		Internal stimulators
		Pacemaker/Defibrillator
		Dentures
		Oral appliance for sleep apnea
		Have you fallen in the past 3 months or do you feel unsteady when standing?

Patient Name: _____

YES	NO	SLEEP SURGICAL HISTORY
		Tonsillectomy-adenoidectomy
		Nasal surgery
		Sinus surgery
		Palate surgery for sleep apnea

DEMOGRAPHIC AND SOCIAL INFORMATION
 Please register for a National Jewish Health patient portal account at nationaljewish.org
This will allow you to receive status updates for PAP therapy orders, request prescription refills, view your schedule, request appointments or cancellations, communicate with your care team and much more.

Emergency contact name: _____ Phone number: _____

Please check your current marital status: Single Married Divorced Widowed

Sleeping habits: Sleep alone With bed partner With pets With children (co-sleeping)

Occupation: _____

<i>Please indicate yes/no and how much per day:</i>	YES	NO	How much per day?
Caffeinated coffee			
Caffeinated tea			
Caffeinated soda			
Energy drinks			
Smoking, chewing tobacco, or e-cigarettes			
Alcohol			
Recreational drugs including marijuana			
Exercise			

YES	NO	SLEEP SCHEDULE
		Do you watch TV, read, or use a computer in bed?
		Do you do shift work or work at night?
		Do you take naps during the day? If so, how long do you nap? _____ What time? _____
		WEEKDAYS
		WEEKENDS
		What time do you get into bed at night?
		What time do you try to fall asleep?
		How long does it take to fall asleep?
		What time do you wake up?
		Average number of hours of sleep per night
		Number of awakenings per night? _____ What causes these awakenings? _____
		How do you feel upon awakening? _____

YES	NO	FAMILY HISTORY – DO ANY OF YOUR FAMILY MEMBERS HAVE:
		Snoring
		Sleep apnea
		Insomnia
		Excessive sleepiness
		Narcolepsy
		Restless legs syndrome

Parents – living or deceased, medical history: _____

Siblings: _____

Other family history: _____

Patient Name: _____

REVIEW OF SYSTEMS –	
PLEASE CHECK ALL THAT HAS OCCURRED OVER THE PAST 12 MONTHS	
<i>Constitutional:</i>	<i>Gastrointestinal:</i>
Weight gain	Reflux
Change in appetite	Heartburn
Weight loss	Abdominal pain
Fatigue	Abdominal bloating
<i>Allergy-Immunology:</i>	<i>Genito-urinary:</i>
Seasonal allergies	Bedwetting
Sneezing	Frequent nighttime urination
<i>Head-eyes:</i>	<i>Endocrine:</i>
Headaches	Cold intolerance
Change in vision	Heat intolerance
<i>Ears-nose-throat:</i>	<i>Musculoskeletal:</i>
Sinus symptoms	Arthritis
Nasal discharge	Fibromyalgia
Nasal congestion	Chronic pain
Nose bleeds	Muscle weakness
Sore throat	<i>Neurologic:</i>
Hoarseness	Seizures
Mouth breathing	Stroke
Ear pain	Memory problems
<i>Lungs:</i>	Concentration problems
Shortness of breath	<i>Psychiatric:</i>
Frequent coughing	Depressed mood
Wheezing	Mild worry
Chest tightness	Anxiety about health
<i>Heart:</i>	Generalized anxiety
Chest pain	Claustrophobia
Palpitations	Post-traumatic stress disorder
Heart failure	<i>Hematologic-Lymphatic:</i>
Leg swelling	Anemia
Sleep with more than 1 pillow	Bleeding
Waking up short of breath at night	<i>Skin:</i>
	Rash
	Eczema/atopic dermatitis

National Jewish Health is a fragrance-free, non-smoking facility. Please do not wear perfumes, colognes, aftershave, scented lotions or scented hairspray as these can irritate and increase respiratory symptoms in our patients and care team.