PATIENT QUESTIONNAIRE

Boise Location
7272 W. Potomac Drive
Boise, ID 83704
(208)884-2922

*****Questionnaire MUST be completed PRIOR to arrival for appointment*****

Today's Date ____/____/____

Last	First	MI	DOB
			____/____/____

Referring Physician	Primary Physician

Please describe reason for visit:

How long have these symptoms bothered you? ____ Year(s) ____ Month(s)
Have you seen a sleep physician before? ____ YES ____ NO
If yes, when and where: ____

Have you had **any kind of sleep study** performed previously? ____ YES ____NO

If **YES**: Please call Dr. Rasmus' office at **884-2922** so all information is available at appointment time.

Revised 03.21.2024

Medical History

	YES	NO
1. Are you pregnant?	☐	☐
2. Alcoholism, drinking condition, or drug abuse. (Please circle)	☐	☐
3. Arthritis or rheumatism (Please circle)	☐	☐
4. Asthma or COPD (please circle)	☐	☐
5. Fibromyalgia	☐	☐
6. Chronic Pain **Please specify** _____	☐	☐
7. Cancer, what type? _____	☐	☐
8. Congenital disease/defect or intellectual disability	☐	☐
9. Diabetes **Pre / Type 1 / Type 2** (Please circle)	☐	☐
10. Migraine headaches	☐	☐
11. Eye, ear, nose, or throat condition **Please specify** _____	☐	☐
12. CHF or Coronary Artery Disease (please circle)	☐	☐
13. High blood pressure? ☐ Yes ☐ No : If **yes**, last reading _____	☐	☐
14. High Cholesterol?	☐	☐
15. Have you had a prior: stroke ☐ or TIA ☐	☐	☐
16. Diagnosed with **Depression, Anxiety** or **Bipolar Disorder** (please circle)	☐	☐
• In the last 2 weeks have you had little interest or pleasure in doing things?	☐	☐
• In the last 2 weeks have you been feeling down, depressed or hopeless?	☐	☐
17. Have you had a mammogram in the last 2 years? Date: _____	☐	☐
18. Have you had a colonoscopy in the last 10 years? Date: _____	☐	☐
19. Flu Vaccine Y ☐ N ☐ Date: _____ Pneumonia vaccine Y ☐ N ☐ Date: _____	☐	☐
20. Other health diagnoses?:	☐	☐

Prior Surgeries (include dates and types):

TYPE	**DATE** mm/yyyy

Prior hospitalizations (include dates and location):

LOCATION and REASON	**DATE** mm/yyyy

Current Medications

(include over the counter and all vitamins)

If you answered yes to any of the above questions, please list all medications below:

Medication	Dose (mg)	Frequency	Date started

Do you have an **allergy** to any medications? ____ NO ____ YES, specify: _____

Other allergies?_____

Family History

Parents: Mother: Living____Age_____ **OR** Deceased____Age____

Father: Living____Age_____ **OR** Deceased____Age_____

Siblings?: Yes ____ No ____

If yes: How many brothers? ____ How many sister?____

Children? : Sons _____ Daughters_____

Ages_____

Are there any **family members** with the following problems? (if so, please specify who):

Sleep Apnea:	Heart Disease:
Reflux/heartburn:	Restless Leg Syndrome:
Allergies/Hay fever:	Periodic Limb Movement Disorder
Asthma:	Insomnia
Eczema:	Narcolepsy
Anxiety/Panic Disorder:	Obesity
Depression:	Seizures
Chronic Fatigue:	Fibromyalgia:
COPD	Other? Please Specify

Social History

Occupation: _____ Marital Status: _____

Whom do you live with? _____

Have you ever or currently smoked cigarettes? ☐ YES ☐ NO

_____ Yrs _____ Packs per day _____ Date quit

Do you have exposure to second hand smoke? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO How many drinks/wk? _____

Caffeinated beverages/day? _____ Any illicit drug use? _____

Prior history of drug or alcohol treatment? _____

Review of Systems

Please circle any of the following problems, which apply to you:

Fever or chills	Joint pain or swelling
Sweat excessively	Headaches
Sinus problems	Fainting spells
Nasal Congestion	Fatigue, loss of energy
Vision problems	Weight loss
Hearing problems	Swollen glands
Heartburn	Hormonal problems (thyroid or other)
Swallowing problems	Blood diseases
Nighttime cough	Low Iron levels
Daytime cough	Speech difficulties
Wheezing	Muscle pain
Breathing/lung problems	Developmental problems
Chest pains	Anxiety/Stress
Diarrhea or constipation	Liver problems
Nausea or Vomiting	Problems urinating
Depression	Fallen in the last year
Panic attacks	

Sleep History

What time do you:
go to bed on weeknights? _____ get out of bed on weekdays? _____
go to bed on weekend nights? _____ get out of bed on weekends? _____
Do you share a bed? _____

Once in bed, how long (on average) does it take you to fall asleep? ___Hours____Minutes

Do you have problems: ☐ **falling asleep** ☐ **staying asleep** ☐ **both?**

How much variation in bedtime/awakening time occurs from night to night?
None ☐ Rarely ☐ Occasionally ☐ A lot ☐

Do you wake during the night? ☐ YES ☐ NO If yes, when? _____
# of awakenings/night? _____ **How long** are you awake? _____

How many times do you urinate nightly? _____

Do you take naps? ☐ YES ☐ NO; # naps/day? _____ How long? _____

Do you snore while sleeping? ☐ YES ☐ NO
If yes, how loud? _____ How frequently? _____

In what position do you sleep? ☐ back ☐ side ☐ sitting up in a chair ☐ other

Do you: breathe through your mouth during day? ☐ YES ☐ NO
breathe through your mouth during night, while sleeping? ☐ YES ☐ NO

Do you or have you been told you:
____sleep talk ____sleep walk ____teeth grind ____have pain in the legs
____have twitching legs awake or asleep ____fall asleep at work ____use sleep aids
____have hallucinations upon falling asleep or upon awakening
____have an inability to move your body (paralysis) upon falling asleep or upon awakening
____have difficulty falling asleep (takes more than 20-30 minutes for you to fall asleep once in bed)
____ever have sleep attacks, or suddenly and unexpectedly fall asleep
____become weak, especially when excited angry or laughing
____fall asleep in odd situations or places
____complain of being sleepy or tired
____gasp, snort, or wake yourself up with your breathing
____have vivid dreams: If yes, have you ever acted them out ____ YES ____ NO
____doze off, have near misses, or accidents when driving
____any recent weight change over the past 12 mths ____Gain____Loss
____have morning headaches
____experience GERD/Reflux/Indigestion at night

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the situations described below, *in contrast to feeling just tired?*

- This refers to your usual way of life in recent times.
- Even if you haven't done some of these things recently, try to work out how they would have affected you.
- Use the following scale to write in the ***most appropriate number*** for each situation.

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Situation	Chance of Dozing			
Sitting and Reading	**0**	**1**	**2**	**3**
Watching T.V	**0**	**1**	**2**	**3**
Sitting, inactive in a public place (e.g., a theater or meeting)	**0**	**1**	**2**	**3**
As a passenger in a car for an hour without a break	**0**	**1**	**2**	**3**
Lying down to rest in the afternoon when circumstances permit	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**
In a car, while stopped for a few minutes in traffic	**0**	**1**	**2**	**3**
Sitting quietly after lunch	**0**	**1**	**2**	**3**

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