Head & Neck Specialty Group of New Hampshire

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Otolaryngology
Head and Neck Surgery
Facial Plastic and Reconstructive Surgery
Allergy
Audiology
Hearing Aids

GENERAL INFORMATION

Name:_____

Address:_____
Street Apt#

_____
City State Zip Code

Home Telephone:(___)_____Work: (___)_____ Cell: (___)_____

Social Security Number: _____ Marital Status: _____

Age____ Date of Birth:____/_____/_____ Sex:_____

Height: _____Weight:_____ Neck Size: _____

Occupation: _____ Years in this job: _____

Are you a shift worker? Yes____ No____

Employer:_____

Address: _____

Referral Source: Physician_____ Newspaper_____ Friend_____

Other____

Referring Physician's Name: _____

Address:_____

Primary Care Physician: _____ Telephone#: _____

Address: _____

Insurance Company: _____

Address: _____

Group No: _____ Policy No: _____

Medicare No.:_____ Medicaid No.: _____

QUESTIONS ABOUT YOUR SLEEP AND WAKE BEHAVIOR

1. Please state in your own words the reason you (or your doctor) contacted our office.

_____

ABOUT FALLING ASLEEP

2. What time do you usually try to fall asleep? _____ a.m.___ p.m._____

3. Does this time vary? _____

4.How long does it usually take you to fall asleep? ____hrs. ___minutes

5.How many days each week does it take you more than 30 minutes to fall asleep?

_____Day(s) More than 60 minutes_____Days_____Never

6. When falling asleep or trying to fall asleep, how often do you:

CHECK ONE FOR EACH STATEMENT	**Never**	**Sometimes**	**Often**
a) have thoughts racing through your mind	☐	☐	☐
b) feel sad or depressed	☐	☐	☐
c) have anxiety (worry about things)	☐	☐	☐
d) feel muscular tension	☐	☐	☐
e) feel afraid of not being able to sleep	☐	☐	☐
f) feel unable to move	☐	☐	☐
g) have creeping, crawling, aching or twitching feeling in your legs(feel like you have to move them	☐	☐	☐
h) have vivid, dream-like scenes even though you know you are not totally asleep	☐	☐	☐
i) have any kind of pain or discomfort	☐	☐	☐
j) feel afraid of the dark or anything else	☐	☐	☐
k) suddenly become aware or alert	☐	☐	☐

7. On average, how many hours of sleep do you get each night? ____hrs.___min.

ABOUT SLEEPING

8. How much does your nightly amount of sleep vary?

From: _____Hours &_____Minutes, to: ___Hours & _____Minutes

9. How many times do you usually awaken each night? _____

Do you have trouble getting back to sleep? _____Yes _____No

10. On a typical night, what is your longest period of wakefulness? ___Hrs. ___Min.

11. How long are you awake all together during the night? _____Hours_____Minutes

12. If you awaken during the night, is it usually during the (CHECK ONE)

a. ☐first half of the sleep period? b. ☐second half of the sleep period?

13. How often do you: (**Check One After EACH STATEMENT)**	**Never**	**Sometimes**	**Often**
a) feel afraid you won't return to sleep after awakening?	☐	☐	☐
b) sleep with someone else in your bed?	☐	☐	☐
c) sleep with someone else in your room?	☐	☐	☐
d) have restless, disturbed sleep?	☐	☐	☐
e) get up at night to attend to your children	☐	☐	☐
f) snore loudly	☐	☐	☐
g) feel your heart pounding during the night?	☐	☐	☐
h) sweat a lot during the night?	☐	☐	☐
i) walk in your sleep?	☐	☐	☐
j) fall out of bed while asleep?	☐	☐	☐
k) wake up screaming, violent or confused?	☐	☐	☐
l) have unusual movements while asleep?	☐	☐	☐
m) wet the bed?	☐	☐	☐
n) have dreams?	☐	☐	☐
o) grind your teeth at night?	☐	☐	☐

14. My sleep is frequently disturbed by: **(CHECK ALL THAT ARE TRUE)**

☐heat	☐choking
☐cold	☐ indigestion, "gas" or heartburn
☐noise	☐hunger
☐noise or movement of your bedpartner	☐thirst
☐asthma	☐need to urinate
☐cough	☐chest pain
☐shortness of breath	☐frightening dreams

☐creeping, crawling, or aching feelings in your legs (like you have to move them)

ABOUT WAKING UP

15. What time do you usually have your final awakening? _____AM/PM

16. What time do you usually get out of bed after your final awakening? _____AM/PM

17. How much does your final awakening time vary? FROM: _____AM/PM

TO: _____AM/PM

18. How often do you:

CHECK ONE FOR EACH STATEMENT	**Never**	**Sometimes**	**Often**
a) depend on an alarm clock to wake up?	☐	☐	☐
b) "sleep-in" in the morning (more than one hour) past your usual wake-up time	☐	☐	☐
c) have a very hard time waking up?	☐	☐	☐
d) feel unable to move when waking up?	☐	☐	☐
e) have dream-like images when waking up even though you know you are not asleep?	☐	☐	☐
f) wake up confused or disoriented?	☐	☐	☐
g) wake up with a headache?	☐	☐	☐
h) wake up nauseous (sick to your stomach)?	☐	☐	☐
i) wake up with a dry mouth?	☐	☐	☐
j) wake up 1 to 2 hours before you have to get up?	☐	☐	☐

OTHER QUESTIONS

19. How much tobacco do you smoke during a 24 hour period?

a. packs of cigarettes? _____

b. cigars? _____

c. (pipe) bowls? _____

20. How often do you use:

CHECK ONE FOR EACH STATEMENT	**Never**	**Sometimes**	**Often**
a) marijuana?	☐	☐	☐
b) cocaine?	☐	☐	☐
c) hallucinogens (LSD, mescaline, angel dust etc..)	☐	☐	☐
d) stimulants (uppers)?	☐	☐	☐
e) depressants (downers)?	☐	☐	☐
f) narcotics (heroin, morphine, opium, etc.)?	☐	☐	☐

21. Please list the name and dose (in mg.) of all medications you take *NOW* or *WITHIN THE PAST 30 DAYS.*

MEDICATION	DOSE	**REASON FOR TAKING**
_____	_____	_____
_____	____	_____
_____	_____	_____
_____	_____	_____

22. Please list the name of any pill for sleeping or to help you stay awake that you taken in the *PAST.*

NAME	**DID IT HELP?**	
_____	☐ Yes	☐No
_____	☐ Yes	☐No
_____	☐ Yes	☐No
_____	☐ Yes	☐No

23. How many times each week do you participate in a sport or partake in some form of exercise?_____

24. What is your personal interpretation as to why you have your particular sleep/wake problem?

_____

25. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate 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	_____
Watching TV	_____
Sitting inactive in a public place (e.g., a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when the circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

(From John MW: A New Method for Measuring Daytime Sleepiness: The Epworth Sleepiness Scale. Sleep 14:540-545, 1991).

HEALTH HISTORY

Present Height_____ Present Weight_____

Has your weight changed recently? ( ) Yes ( ) No If yes, explain _____

_____

Please check any problem or illness you have or have had:

☐ Heart Disease	☐ High Blood Pressure	☐ Heart Attack
☐ Low Blood Pressure	☐ Fainting	☐ Dizziness
☐ Headaches	☐ Ringing of the Ears	☐ Epilepsy
☐ Blackouts	☐ Hemophilia (Bleeder)	☐ Ulcers
☐ Hernia	☐ Prostate Trouble	☐ Mental Problems
☐ Back Trouble	☐ Gout	☐ Seizures
☐ Asthma	☐ Allergies	☐ Bronchitis
☐ Cancer	☐ Kidney Trouble	☐ Bladder Trouble
☐ Eye Trouble	☐ Hearing Trouble	☐ Pneumonia
☐ Meningitis	☐ Heartburn	☐ Impotence
☐ Depression	☐ Venereal Disease	☐ Arthritis
☐ Tuberculosis	☐ Muscle Cramps	

SURGERIES & HOSPITALIZATIONS
Please list any hospitalizations and/or surgeries you have had. LIST THE LATEST FIRST and include where, what, why, and when.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

BED PARTNER QUESTIONNAIRE

Name of Patient: _____ Date: _____

Name of Person filling out this form: _____

I have observed this person's sleep ( ) Never ( ) Once or twice ( ) Often ( ) Every night

Check any of the following behaviors that you have observed this person doing *while asleep.*

☐ Light snoring	☐ Loud snoring	☐ Occasional loud snorts
☐ Choking	☐ Pauses in breathing	☐ Twitching or kicking of legs during sleep
☐ Grinding teeth	☐ Sleepwalking	☐ Twitching or jerking of arms during sleep
☐ Bed wetting	☐ Biting tongue	☐ Getting out of bed but not awake
☐ Crying out	☐ Sitting up in bed not awake	☐ Awakening with pain
☐ Head rocking or banging	☐ Becoming very rigid and/or shaking	☐ Apparently sleeping even if he/she behaves otherwise

☐ Other_____

Please describe the sleep behaviors checked in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

_____

_____

_____

_____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations?

( ) Yes ( ) No If yes, explain _____