WENTWORTH HEALTH PARTNERS

Seacoast Pulmonary Medicine Sleep Disorder Evaluation Questionnaire

Date _____
Name _____
Date of Birth _____
Height _____
Weight _____

1. Major Complaints:
   a. _____
   b. _____
   c. _____

2. Sleep Time:
   Length of night sleep _____
   Normal sleep hours _____

   Snoring ☐
   Body movement with sleep ☐
   Vivid dreams or hallucinations ☐
   Restless in bed ☐
   Number of awakenings ☐ Why _____

   Wake Time:
   Paralysis on awakening ☐
   Headaches ☐
   Daytime sleepiness ☐
   Daytime naps ☐ #_____
   Daytime paralysis/falling attacks ☐

3. Prior to bedtime:
   Caffeine(tea, soda, choc) ☐ amount _____ Medication ☐_____
   Alcohol ☐ amount _____ Exercise ☐_____

   Caffeine intake during the day (tea, soda, coffee) _____

4. Past Medical History:
   High blood pressure ☐_____
   Diabetes ☐_____
   Thyroid disorder ☐_____
   Kidney disease ☐_____
   Cardiac disease ☐_____
   Lung disease ☐_____
   Others ☐_____

   Past Surgical History:
   Tonsils ☐_____
   Adenoids ☐_____
   Nasal septum ☐_____
   Face/Jaw injury ☐_____
   Cardiac ☐_____
   Head injury ☐_____
   Other surgery ☐_____

   Past psychiatric history:
   Depression ☐ Anxiety disorder ☐ Panic Attacks ☐ ADHD ☐

   Family History:
   Lung Disease ☐_____
   Sleep apnea ☐_____
   Snoring ☐_____
   Other ☐ _____

   Hypertension ☐_____
   Diabetes ☐_____
   Cardiac disease ☐_____

5. Current Medications (add separate list if necessary):
   _____ _____
   _____ _____
   _____ _____