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Sutter Health
Sutter Sleep Disorders Center

Pre-Arrival Questionnaire

Name: _____ Date of Study: _____

If under 18, Parent/Guardian Name _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Referring Physician: _____ Phone #: _____

Referring Physician's Address: _____

Primary Physician: _____ Phone #: _____

Primary Physician's Address: _____

Chief Compliant _____

I. Do you snore? ☐ Yes ☐ No is it? ☐ Soft ☐ Medium ☐ Loud

Is your sleeping partner affected? ☐ Yes ☐ No ☐ N/A

How many nights a week? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Do you snore all night? ☐ Yes ☐ No ☐ Don't Know

How many years have you been snoring? _____

II. Has anyone seen you stop breathing while asleep? ☐ Yes ☐ No ☐ Don't Know

What was the longest you stopped breathing? _____

How many times in one night does this happen? _____

Does your chest stop moving during the pauses? ☐ Yes ☐ No ☐ Don't Know

III. What is your typical sleeping position? ☐ Side ☐ Back ☐ Stomach

How many pillows? _____

IV. What time do you go to sleep? _____

What time do you get up? _____

Do you get up during the night? ☐ Yes ☐ No

How many times? _____

Do you take naps during the day? ☐ Yes ☐ No

How many / how long? _____ / _____

V. Please check the appropriate letter for each question:

N = Never O = Occasionally F = Frequently C = Constantly

1. Excessive daytime sleepiness	☐ N	☐ O	☐ F	☐ C
2. Sweating when asleep	☐ N	☐ O	☐ F	☐ C
3. Restless sleep / arousals	☐ N	☐ O	☐ F	☐ C
4. Nighttime shortness of breath	☐ N	☐ O	☐ F	☐ C
5. Nighttime choking / coughing	☐ N	☐ O	☐ F	☐ C
6. Nightly muscle activity / leg kicking	☐ N	☐ O	☐ F	☐ C
7. Night paralysis (wake up and can't move)	☐ N	☐ O	☐ F	☐ C
8. Nightly reflux / heartburn	☐ N	☐ O	☐ F	☐ C
9. Morning headaches / nausea	☐ N	☐ O	☐ F	☐ C
10. Nightmares / Hallucinations	☐ N	☐ O	☐ F	☐ C
11. Sleep walking	☐ N	☐ O	☐ F	☐ C
12. Chest pain at night	☐ N	☐ O	☐ F	☐ C
13. Grind teeth at night	☐ N	☐ O	☐ F	☐ C

VI. Please include a list of your current medications:

_____ _____

_____ _____

_____ _____

_____ _____

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VII. Have you ever.....

..... been diagnosed with any respiratory problems? ☐ Yes ☐ No

..... had a history of abnormal ear/ nose/ throat structure? ☐ Yes ☐ No

..... had oral surgery? ☐ Yes ☐ No

..... had neurological testing? ☐ Yes ☐ No

..... had neurosurgery? ☐ Yes ☐ No

..... been diagnosed with depression or anxiety? ☐ Yes ☐ No

..... been diagnosed with heart problems? ☐ Yes ☐ No

If so, please explain _____

..... been diagnosed with blood pressure problems? ☐ Yes ☐ No

Is it controlled with medication? ☐ Yes ☐ No

..... been diagnosed with sleep apnea? ☐ Yes ☐ No

When / Where? _____ / _____

Was treatment prescribed? ☐ Yes ☐ No

If so, please explain _____

Any changes since diagnosis? ☐ Yes ☐ No

If so, please explain _____

If you are a current CPAP user call 2-3 days prior to study: (916) 887-4001

VIII. Learning/Development Problems **(pediatric patients only)**: (N/A – Non-applicable)

A. Delayed Development ☐ Yes ☐ No ☐ N/A

B. Speech Problems ☐ Yes ☐ No ☐ N/A

C. Poor School Performance ☐ Yes ☐ No ☐ N/A

D. Special School	☐ Yes	☐ No	☐ N/A
E. Poor appetite	☐ Yes	☐ No	☐ N/A
F. Frequent nausea/vomiting	☐ Yes	☐ No	☐ N/A
G. Difficulty swallowing	☐ Yes	☐ No	☐ N/A
H. Constant nose running	☐ Yes	☐ No	☐ N/A
I. Recurrent middle ear disease	☐ Yes	☐ No	☐ N/A
J. Hearing problem	☐ Yes	☐ No	☐ N/A
K. Mouth breathes when awake	☐ Yes	☐ No	☐ N/A
L. Frequent respiratory infections	☐ Yes	☐ No	☐ N/A
M. History of pneumonia	☐ Yes	☐ No	☐ N/A

IX. Do you .....

..... feel there's been a loss of concentration or memory recently?	☐ Yes	☐ No
..... feel any personality changes?	☐ Yes	☐ No
..... have any allergies?	☐ Yes	☐ No
..... smoke?	☐ Yes	☐ No
How much?	_____	
..... drink alcohol?	☐ Yes	☐ No
How much?	_____	
..... drink caffeinated beverages?	☐ Yes	☐ No
How much?	_____	

X. What is your type of work? _____

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XI. What motivated you to get a sleep study? (check all that apply)

- ☐ Television, Radio or Magazine
- ☐ Health Literature or Presentation
- ☐ Physician or Dentist
- ☐ Spouse or Friend
- ☐ Employer
- Other: _____

Do you have any other medical issues? ☐ Yes ☐ No

If so, please explain:

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Epworth Sleepiness Scale

Name: _____

Date: _____

Age (Yrs): _____ **Gender:** ☐ Male ☐ Female

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.*

Use the following scale to choose 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

It is important that you answer each question as best you can.

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in 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 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	_____

THANK YOU FOR YOUR COOPERATION

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Pre-Sleep Questionnaire

Name: _____ **Date of Study:** _____

Date of Birth: _____ **Age:** _____ **Height:** _____ **Weight:** _____

1. General Functioning last night

	(bad)				(very good)
Quality of Sleep	☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Daytime Energy	☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Ability Staying Awake	☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Job Performance	☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**

2. What time did you wake up today? _____

3. Did you get your normal amount of sleep last night? ☐ **Yes** ☐ **No**

4. Did you have any caffeinated or alcoholic beverages today? ☐ **Yes** ☐ **No**

5. Have you taken your medications today? ☐ **Yes** ☐ **No**

6. Substance use in the last 24 hours/

Tranquilizers	☐ **Yes**	☐ **No**
Marijuana	☐ **Yes**	☐ **No**
Opiates (codeine, MS, heroin)	☐ **Yes**	☐ **No**
Alcohol	☐ **Yes**	☐ **No**
Amphetamines (cocaine, crack, diet pills)	☐ **Yes**	☐ **No**
Tobacco	☐ **Yes**	☐ **No**
Hallucinogens (PCP, LSD)	☐ **Yes**	☐ **No**
Other: _____		

7. Did you do any exercising today? ☐ **Yes** ☐ **No**

8. Have you recently gained weight without trying? ☐ **Yes** ☐ **No**

9. When did you eat your last meal? _____

10. Any physical complaints today? ☐ **Yes** ☐ **No**

11. Are you in pain right now? ☐ **Yes** ☐ **No**
    If yes, what is the intensity? **0 → 10** _____

12. Are you currently a victim of domestic violence? ☐ **Yes** ☐ **No**

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We will automatically provide the results of your study to the physician that referred you for the test. If there are any other physicians that you would like to receive a copy of your sleep study, please list them here:

Patient Name: _____ Date of Birth: _____

PRIMARY CARE PHYSICIAN

Name: _____

Phone #: _____

Fax #: _____

EAR, NOSE, & THROAT

Name: _____

Phone #: _____

Fax #: _____

PULMONOLOGIST

Name: _____

Phone #: _____

Fax #: _____

CARDIOLOGIST

Name: _____

Phone #: _____

Fax #: _____

OTHER

Name: _____

Phone #: _____

Fax #: _____