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Medical Questionnaire

The purpose of this questionnaire is to help our physician understand the nature of your complaints and possible sleep disorder. All information contained in this questionnaire will be held in strict confidence. In order to assist us in serving you better, please answer each question complete and as accurate as possible. Some of the questions may not pertain to your specific complaint, but still answer them as best you can. It may be helpful to consult family members on some questions.

Name: _____ Date: _____

Referring Physician: _____

Primary Care Physician: _____

Are you? RIGHT Handed [] LEFT Handed [] BOTH []

What is the main problem for which you are being seen today?

How long have you had this problem? _____

Social History: (circle/fill in best answer)

Marital Status: Married Single Life Partner Separated Divorced Widowed

Tobacco Use: Never previously, but quit Current, packs per day _____

Alcohol Use: Do you currently drink alcohol? Yes or No
How much per day? _____ per week? _____

Drug Use: Never previously, but quit Type & Frequency _____

Caffeine Use: Never Cups per day _____

Occupation: Do you work outside of the home? Yes No Retired
What kind of work do you do? _____

Do you work shifts? Yes No Variable or Stable? _____

Exposure: Do you have excessive exposure at home or work to:
fumes dust solvents air-borne particles

Family History: (complete all that applies)

Table with 4 columns: Family Member, Age at Onset, Disease(s), If deceased, cause of death. Rows include Father, Mother, Brother(s), Sister(s), and Children (How many?).

Name: _____

Date: _____

Review of Systems: (please circle yes or no)

Constitutional Symptoms:

- Y N Good general health lately
- Y N Recent weight loss
- Y N Recent weight gain
- Y N Fever
- Y N Fatigue
- Y N Loss of appetite

Eyes:

- Y N Eye disease
- Y N Double vision
- Y N Wear corrective lenses
- Y N Visual loss
- Y N Blurred vision

Ears/Nose/Mouth/Throat:

- Y N Hearing Loss
- Y N Ringing in ears
- Y N Earaches
- Y N Swallowing problems
- Y N Chronic sinus problem

Cardiovascular:

- Y N Heart disease
- Y N Chest pain
- Y N Ankle swelling
- Y N Palpitations
- Y N Shortness of breath with walking
- Y N Shortness of breath while lying flat
- Y N Irregular heart beat
- Y N Calf pain with activity

Respiratory:

- Y N Frequent cough
- Y N Asthma
- Y N Wheezing

Gastrointestinal:

- Y N Diarrhea
- Y N Nausea
- Y N Vomiting
- Y N Constipation
- Y N Blood in stool
- Y N Abdominal pain
- Y N Heartburn
- Y N Ulcer

Genitourinary:

- Y N Frequent urination
- Y N Blood in urine
- Y N Incontinence
- Y N Kidney stones
- Y N Sexual difficulties
- Y N Male/testicle pain
- Y N Female/irregular periods
- Y N Urgency
- Y N Painful urination

Musculoskeletal:

- Y N Joint pain
- Y N Joint stiffness
- Y N Muscle cramps
- Y N Back pain

Integumentary (skin)

- Y N Rash
- Y N Itching
- Y N Change in skin color

Sleep Problems:

- Y N Do you sleep well?
- Y N Leg jerks at night?
- Y N Do you snore?
- Y N Are you fatigued on awakening?
- Y N Stop breathing at night?
- Y N Grind your teeth?

Previous Diagnosis of:

- Y N Sleep apnea
- Y N Restless leg syndrome
- Y N Narcolepsy

Psychiatric:

- Y N Memory loss
- Y N Confusion
- Y N Nervousness
- Y N Depression
- Y N Anxiety

Endocrine:

- Y N Thyroid disease
- Y N Diabetes
- Y N Excessive thirst
- Y N Heat intolerance
- Y N Cold intolerance

Neurologic:

- Y N Numbness
- Y N Tingling
- Y N Speech difficulties
- Y N Gait difficulties
- Y N One sided weakness
- Y N Tremor
- Y N Fainting
- Y N Swallowing difficulties

Name: _____

Date: _____

Sleep History

What time do you go to bed? _____ AM PM

How long does it take you to fall asleep? _____

How often do you awaken from sleep? _____

If you awaken, how long does it take you to return to sleep? _____

What time do you normally awaken? _____ AM PM

Do you grind your teeth at night? Y N

Do you sleep walk? Y N

Do you talk in your sleep? Y N

When falling asleep:

Have you ever hallucinated (seen or heard things that were not real)? Y N

Have you experienced itching or a crawling sensation in your legs? Y N

Have you experienced a burning discomfort in your feet? Y N

Have you experienced leg jerking at night? Y N

On awakening:

Have you ever been awake, but unable to move? Y N

Have you found that you had bitten your tongue? Y N

Have you been incontinent of bowels or bladder? Y N

During the day have you experienced episodes of weakness of the Face, arms, or legs when laughing, angry, or in stressful situations? Y N

Do you have morning headaches? Y N

Have you ever awakened screaming at night? Y N

Do you wake up choking or gasping? Y N

Name: _____

Date: _____

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 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

Situation:	Chance of dozing:
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting, inactive in a public place	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 afternoon	0 1 2 3
Sitting and talking with someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in traffic	0 1 2 3

Total: _____

Name: _____

Date: _____

ZUNG SELF-RATING DEPRESSION SCALE
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Please read each statement and decide how much of the time the statement describes how you have been feeling during the past several days.

Make check mark (v) in appropriate column:

		A little of the time	Some of the time	Good part of the time	Most of the time
1	I feel down-hearted and blue				
2	Morning is when I feel the best				
3	I have crying spells or feel like it				
4	I have trouble sleeping at night				
5	I eat as much as I used to				
6	I still enjoy sex				
7	I notice that I am losing weight				
8	I have trouble with constipation				
9	My heart beats faster than usual				
10	I get tired for no reason				
11	My mind is as clear as it used to be				
12	I find it easy to do the things I used to				
13	I am restless and can't keep still				
14	I feel hopeful about the future				
15	I am more irritable than usual				
16	I find it easy to make decisions				
17	I feel that I am useful and needed				
18	My life is pretty full				
19	I feel others would be better off if I were dead				
20	I still enjoy the things I used to do				

Total: _____