ALASKA SLEEP CLINIC
an ALYESKA INTERNATIONAL, INC. company

Anchorage
3920 Lake Otis Pkwy., Ste.101
Anchorage, AK 99508
P: 907.770.9104
F: 907.770.8965

Fairbanks
1901 Airport Way, Ste. 101
Fairbanks, AK 99701
P: 907.374.3063
F: 907.374.8872

Soldotna
588 Pace Street
Soldotna, AK 99669
P: 907.420.0540
F: 907.420.0541

Wasilla
1051 East Bogard Rd., Ste. 1
Wasilla, AK 99654
P: 907.357.6700
F: 907.357.6672

Patient Questionnaire

Patient Information:

Patient Last Name:______________________________First Name:_____________________________DOB:___________________Sex:____

Mailing Address:____City:___________________________State/Zip:______________________

Home / Cell Phone: _____________________________Work Phone: ___________________ Referring Physician:_____________________

Please describe why you need a sleep study at this time:

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Sleep Schedule

1.	What time on weekdays do you usually	Go to bed? __________	Wake up? __________
2.	What are your usual working hours if applicable	Begin? _____________	End?______________
3.	What time on weekends do you usually	Go to bed? __________	Wake up? __________
4.	On average, how long do you actually sleep at night?	Weekdays? _________	Weekends? _________
5.	Do you feel you get too much or too little sleep at night?	Too much? __________	Too little? __________

Nighttime Symptoms

6	How long does it normally take you to fall asleep at night?	Minutes ____________			
7	Do you have thoughts that prevent sleep?	______ Yes	______ No		
8	Do you have trouble getting to sleep at night?	______ Yes	______ No		
9	Do you awaken at night to use the bathroom?	______ Yes	______ No	How often?	___________
10	Are you ever awakened by a "coughing spell" during the night?	______ Yes	______ No		
11	Do you have crawling sensation in your legs when falling asleep?	______ Yes	______ No		
12	Do you have twitching movements in your legs during the night?	______ Yes	______ No		
13	Do you awaken with racing thoughts, sadness or anxiety?	______ Yes	______ No		
14	Have other people told you that you have restless sleep?	______ Yes	______ No		
15	Do you have difficulty going back to sleep during the night?	______ Yes	______ No		
16	Does anyone tell you, you snore badly?	______ Yes	______ No		
17	Do you have difficulty breathing at night?	______ Yes	______ No		
18	Do you wake up with headaches?	______ Yes	______ No	How often?	___________
19	Do you awaken with a sour or bitter taste in your mouth?	______ Yes	______ No		
20	Is it difficult for you to awaken & get out of bed after sleeping?	______ Yes	______ No		
21	Have you experienced paralysis upon awakening from sleep?	______ Yes	______ No		

22	Do you have vivid dreams as you are falling asleep?	______ Yes	______ No				
23	Is your sleep disturbed by a medical problem?	______ Yes	______ No	How often? ______			

Daytime Symptoms

24	Do you deliberately take naps during the day?	___ Yes	___ No	How often?	___	How Long?	______
25	Do you feel rested or refreshed after a nap?	___ Yes	___ No				
26	Are you bothered by sleepiness during the day?	___ Yes	___ No	How often?	___		
27	Do you find yourself falling asleep when you don't mean to?	___ Yes	___ No	How often?	___		
28	Do you take naps during the day?	___ Yes	___ No	I want to but can't	___	Number of times per week?	______

29 Do you fall asleep during these situations?

0 = no chance of dozing, 1 = slight chance of dozing, 2 = moderate chance of dozing, 3 = high 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 with out a break	0	1	2	3
Lying down to rest in afternoon when circumstances permit	0	1	2	3
Sitting and talking to 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 of all answers: ______

30. Have you ever had the following kinds of weakness develop suddenly during an emotional situation? (for example, when laughing, if angry, if in an exciting situation, etc.)?

Knees buckling	Never	1-5 times in your life	Monthly	Weekly	Daily	Almost daily
Mouth opening	Never	1-5 times in your life	Monthly	Weekly	Daily	Almost daily
Head nodding	Never	1-5 times in your life	Monthly	Weekly	Daily	Almost daily
Falling down	Never	1-5 times in your life	Monthly	Weekly	Daily	Almost daily

31. Do you know, or others tell you that you:

	Age Started	Last Occurred	Frequency	Treatment
Talk while apparently asleep?	______	______	______	______
Walk while apparently asleep?	______	______	______	______
Grit teeth while apparently asleep?	______	______	______	______
Wake up screaming, anxious or afraid?	______	______	______	______
Have disturbing dreams (nightmares)?	______	______	______	______
Have unusual movements while asleep?	______	______	______	______

32. Health history. Please mark all that apply.

___ Weight Problems	___ Tonsillectomy	___ Lung Disease	___ Heart Disease	___ Stroke
___ High blood pressure	___ Sinus Surgery	___ Ulcers	___ Neurologic Disease	___ Cancer
___ Shortness of breath	___ Chronic Cough	___ Colitis	___ Anxiety	___ Narcolepsy
___ Deviated nasal septum	___ Chronic Bronchitis	___ Kidney problems	___ Dementia	___ Chronic Fatigue
___ Sinus Problems	___ Asthma	___ Thyroid Disorder	___ Depression	___ Fibromyalgia
___ Emphysema	___ Diabetes	___ Psychiatric	___	___ Parkinson's

33. Please list any other health or surgical history:

____

____

____

34. Does anyone in your family have sleep problems?

Relationship to you: Problem:

____________________ ____

____________________ ____

____________________ ____

____________________ ____

35. For each of the beverages below, please write the average amount that you drink per day:

Regular Coffee (cups)		Hot or Iced Tea (cups)		Caffeinated Drinks	

36. Do you smoke cigarettes? _______Yes _______No

If yes, how many packs per day? _______ For how may years?_______________________

If no, did you ever smoke? _______Yes _______No When did you stop?_______________

37. How many alcoholic beverages do you drink per day during the week? ____________ per month? ____________

Medications - Please list your current medications below:

Medication	Amount/Dose	How Often	Years	Reason

Additional Information:

38. If there are any other aspects of your sleep that you feel are important, please describe them below:

____

____

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