920 Copperfield Blvd, NE
Concord, NC 28025
Phone: (704) 707-4120
Fax: (704) 706-9520

New Patient Questionnaire

___Requested Study (Office Use Only)

Today's date: _____/______/________ **Social Security #:** ______-______-_______ **E-mail:** ___________________________________

First Name: _______________________________ **Last Name**: _______________________________________ **Middle Initial**: _______

Height: ________ ft._______**inches** **Weight**: _______lbs. **Neck Size**: __________ inches

Marital Status: **Single** **Married** **Divorced** **Separated** **Widowed** **Partner**

Doctor who sent you here: ____

Your primary physician? ____

Can we send them a copy of the office notes? *No* *Yes*

Have you ever been diagnosed with sleep apnea? *No* *Yes, When:* ____

Have you ever had a sleep study? *No* *Yes, Where, when:* ____________________________________

Have you ever been on CPAP or BiPAP? *No* *Yes, when:* ____

What is your preferred pharmacy? ____

PLEASE PUT THE ANSWER THAT BEST DESCRIBES YOUR SITUATION.

Are you drowsy during the day without caffeine?	*Never*	*Mild*	*Moderate*	*Severe*
Do you snore when you sleep?	*Never*	*Mild*	*Moderate*	*Severe*
Have you ever woken up gasping or choking?	*Never*	*Rare*	*Intermittent*	*Frequent*
Has anyone ever witnessed you stop breathing in your sleep?	*Never*	*Rare*	*Intermittent*	*Frequent*
How often do you get drowsy while driving?	*Never*	*Rare*	*Intermittent*	*Frequent*
Have you fallen asleep while driving?	*Never*	*Rare*	*Intermittent*	*Frequent*
Have you felt completely paralyzed upon waking up?			*No*	*Yes*
Have you experienced sudden muscle weakness while laughing?			*No*	*Yes*

GETTING TO SLEEP:

Do you ever have difficulty falling asleep?	*Never*	*Rare*	*Intermittent*	*Frequent*
How severe is it?		*Mild*	*Moderate*	*Severe*
Do you have trouble "turning your brain off" when trying to fall asleep?	*Never*	*Rare*	*Intermittent*	*Frequent*
How often does pain interfere with you falling asleep?	*Never*	*Rare*	*Intermittent*	*Frequent*
Do you think of how bad/tired you will feel the next day if you don't sleep well at night?	*Never*	*Rare*	*Intermittent*	*Frequent*

STAYING ASLEEP:

Do you ever have difficulty staying asleep at night?	*Never*	*Rare*	*Intermittent*	*Frequent*
How often do you awaken during the night?	*Never*	*Rare*	*Intermittent*	*Frequent*
How often does pain prevent you from staying asleep?	*Never*	*Rare*	*Intermittent*	*Frequent*

DURING SLEEP:

Does your bed-partner say your legs jump while asleep?	*Never*	*Rare*	*Intermittent*	*Frequent*
Are you all over the bed at night?			*No*	*Yes*
Do you have an irresistible urge to move your legs?			*No*	*Yes*
How often do you sleep walk?	*Never*	*Rare*	*Intermittent*	*Frequent*
How often do you talk in your sleep?	*Never*	*Rare*	*Intermittent*	*Frequent*
How often do you act out dreams at night?	*Never*	*Rare*	*Intermittent*	*Frequent*

OFFICE USE ONLY: CHECK IN: HTN / LT / NONE INTAKE: SHIFT / TOB / NONE

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PAST MEDICAL HISTORY: Please circle any conditions that you have, or add any additional conditions.

ADHD/ADD	**Anemia**	**Anxiety Disorder**	**Arthritis**
Atrial Fibrillation	**Bipolar Disorder**	**Brain Contusion**	**Brain Tumor**
Broken Nose	**COPD**	**Cancer**	**Chronic Fatigue**
Chronic Pain	**Congestive Heart Failure (CHF)**	**Coronary Artery Disease (CAD)**	**Depression**
Deviated Septum	**Diabetes**	**Dialysis**	**Emphysema**
Environmental Allergies	**Erectile Dysfunction (ED)**	**Fibromyalgia**	**Gout**
Head Trauma	**Heart Attack**	**Heart Disease**	**Heart Murmurs**
High Cholesterol	**Hypertension**	**Hyperthyroidism**	**Insomnia**
Iron Deficiency	**Irregular Heart Beat**	**Irritable Bowel Syndrome (IBS)**	**Kidney Disease**
Kidney Stones	**Liver Disease**	**Low Testosterone (Low T)**	**Migraines**
Mononucleosis	**Multiple Sclerosis (MS)**	**Obesity**	**Osteoporosis**
Panic Attack	**Parasomnia**	**Parkinson's Disease**	**Peripheral Neuropathy**
Post-Traumatic Stress Disorder (PTSD)	**Pulmonary Embolism (PE)**	**Reflux/GERD**	**Restless Legs Syndrome (RLS)**
Schizophrenia	**Seizures**	**Sinus Problems**	**Sleep Apnea**
Sleep Related Teeth Grinding	**Stroke**	**Thyroid Disease**	

List any other problems not noted above:

____
____

MEDICATIONS: (If bringing list please note SEE LIST)

Drug	Dosage	How Often Taken	Reason

Drug Allergies/ Adverse Reactions: List medication and reaction to it. (EX: Tegretol-rash; or "no known allergies")

____
____
____

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REVIEW OF SYSTEMS:

Circle if you have any of the symptoms below:

*** If you have any of the following symptoms, you should address them with you Primary Care Physician. ***

CONSTITUTIONAL SYMPTOMS:	Unexplained fevers /chills/rashes		
EYES:	Dim vision		
EARS, NOSE, MOUTH, THROAT:	*Dentures*	*Hole in eardrum (Year) _______*	*Deviated septum*
CARDIOVASCULAR:	*Heart murmur*	*Irregular heart beat*	
RESPIRATORY:	*Coughing up blood*	*Daytime Breathing through nose difficult*	*Asthma*
GASTROINTESTINAL:	*Throwing up blood*	*Blood in Stool*	*Reflux / GERD*
GENITOURINARY:	*Pain with urinating*	*Kidney stones*	*Excessive Urinating at Night*
MUSCULOSKELETAL:	*Neck pain*	*Back pain*	*Joint pain*
INTEGUMENTARY (SKIN AND/OR BREAST):	Unexplained Rash/hives		
NEUROLOGICAL:	*Seizures*	*Migraines*	
PSYCHIATRIC:	*Depression*	*Anxiety*	
ENDOCRINE:	*Fatigue*	*Erectile dysfunction "ED"*	*Impotence*
HEMATOLOGIC/LYMPHATIC:	*Excessive bleeding*	*Anemia*	
ALLERGIC/IMMUNOLOGIC:	*Hayfever/Environmental Allergies*		