MedStar Montgomery Medical Center

Please fill out the following questionnaire as completely as possible and bring it with you to your first appointment at the sleep center. All information will be kept confidential.

Name:______________________________________Date:___________ Email:___________________________

Height:____________Weight:____________ Male ___ Female ___

Date of Birth: ___________ Social Security Number: ________________ Occupation: __________________

Referring Physician: ________________________ Family Physician: ___________________________

Presenting Complaint:____

Medical History:____

____

Medications:____

____

What time do you normally go to sleep?____

When do you normally wake up?____

How many times do you wake up during the night?______________________________________

How long are you awake during the night?____

How long does it take for you to fall asleep at night? _____________________________________

How many naps do you take during the day?____

How long are your naps?____

Do you have excessive daytime sleepiness? (circle one) Yes No

Does this sleepiness affect your work or social life? (circle one) Yes No

Do you fall asleep while driving? (circle one) Yes No

Have you had a car accident secondary to sleepiness? (circle one) Yes No

Do you snore? (circle one) Yes No

Do you stop breathing at night? (circle one) Yes No

Do you feel refreshed in the morning? (circle one) Yes No

Do you have morning headaches? (circle one) Yes No

Do your legs bother you at night? (circle one) Yes No

Do you have restless legs at night? (circle one) Yes No

Do you have chronic pain that affects your sleep? (circle one) Yes No

Did you ever wake up absolutely unable to move? (circle one) Yes No

Has a strong emotion ever caused muscle weakness? (circle one) Yes No

Have you ever acted out dream content? (circle one) Yes No

Have you ever had a seizure disorder? (circle one) Yes No

How many alcoholic drinks do you have per day?____

How many caffeinated drinks do you have per day?______________________________________

Do you have any relatives with a sleep disorder? If so, what disorder?______________________

Are you allergic to any type of tape? (circle one) Yes No

Do you now or have you ever had any of the following? (circle one)

Excessive Daytime Sleepiness	Yes	No
Lethargy (sluggish)	Yes	No
Chest Pain	Yes	No
Syncope (feel faint)	Yes	No
Hemoptysis (cough up blood)	Yes	No
Pleurisy	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Seizure	Yes	No
Headaches	Yes	No

If you have any questions, please contact our office at (301) 774-8736.

Thank you,
Mark Miller, MD
Medical Director
Board Certified Sleep Medicine