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Patient Sleep Questionnaire

Name _____ Marital Status: S M W D
 Last First Middle
 Address _____ City _____ State _____ Zip Code _____
 Home Phone # _____ Emergency # _____ Cell #: _____ Date of Birth _____ Age: _____
 Employed By: _____ Occupation _____ Social Security # _____
 Business Address: _____ City _____ State _____ Zip Code _____
 Business Phone#: _____ Fax #: _____ E-mail: _____
 Medical Insurance Carrier, Self _____ Group #: _____
 Dental Insurance Carrier, Self _____ Group #: _____
 Spouse's Name _____ Date of Birth _____
 Spouse Employed By: _____ Occupation: _____ Social Security # _____
 Spouse's Business Address: _____ City _____ State _____ Zip Code _____
 Spouse's Business Phone# _____ Fax # _____ E-mail _____
 Spouse's Medical Insurance Carrier _____ Group #: _____
 Spouse's Dental Insurance Carrier _____ Group #: _____
 Referred to Dr. Carollo's office by: _____

Medical History: Please Write Your Answers As Complete As Possible; All Information Is Confidential

Physician's Name Address and Phone #: _____

 Sleep Physician or Pulmonologist's Name Address and Phone #: _____

 Height _____ Weight _____ Weight gain or loss, (10 lbs or more): Yes / No
 My normal work hours / days are: _____
 1. Are you presently under the care of a physician? _____ Date of last Exam _____
 If Yes, for what condition? _____
 2. Has there been any change in your general health within the past year? _____ Explain _____
 3. Have you ever had a serious illness? _____ If Yes, Please Explain _____
 4. Are you presently taking any medications? _____ Please Identify and explain need: _____

 5. Have you ever had high blood pressure? _____ or low blood pressure? _____
 6. Have you ever had Heart Disease? Angina? Heart Attack? Congestive Heart Failure? _____ When? _____
 7. Have you ever had Diabetes? _____ If yes, date of onset _____

(over)

8. Have you had Bypass Surgery? _____ When? _____
9. Have you ever had Asthma, Bronchitis, or Emphysema? _____ When? _____
10. Have you ever had Tonsillectomy or Adenoidectomy? _____ When? _____
11. Have you ever had a Stroke? _____ When? _____
12. Do you smoke? _____ Number of packs per day? _____
13. Have you ever had Hiatal Hernia or Acid Reflux? _____
14. Have you had any recent surgeries? Please list: _____

Sleep History: These questions help us understand your sleep habits better

My complaint(s) is (are):

I have experienced these symptoms for:

- | | | | | | |
|---|--------------------------------------|--|------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> 1-18 months | <input type="checkbox"/> 19 months to 5 yrs. | <input type="checkbox"/> 6-10 yrs. | <input type="checkbox"/> 11-20 years | <input type="checkbox"/> 20+ yrs. |
| <input type="checkbox"/> My Breathing Stops | <input type="checkbox"/> 1-18 months | <input type="checkbox"/> 19 months to 5 yrs. | <input type="checkbox"/> 6-10 yrs. | <input type="checkbox"/> 11-20 years | <input type="checkbox"/> 20+ yrs. |
| <input type="checkbox"/> I'm sleepy | <input type="checkbox"/> 1-18 months | <input type="checkbox"/> 19 months to 5 yrs. | <input type="checkbox"/> 6-10 yrs. | <input type="checkbox"/> 11-20 years | <input type="checkbox"/> 20+ yrs. |
| <input type="checkbox"/> I can't fall asleep or stay asleep | <input type="checkbox"/> 1-18 months | <input type="checkbox"/> 19 months to 5 yrs. | <input type="checkbox"/> 6-10 yrs. | <input type="checkbox"/> 11-20 years | <input type="checkbox"/> 20+ yrs. |
| <input type="checkbox"/> I talk or walk in my sleep | <input type="checkbox"/> 1-18 months | <input type="checkbox"/> 19 months to 5 yrs. | <input type="checkbox"/> 6-10 yrs. | <input type="checkbox"/> 11-20 years | <input type="checkbox"/> 20+ yrs. |
| <input type="checkbox"/> Other, please comment: _____ | | | | | |

1. How long does it take you to fall asleep? _____ minutes _____ hours
2. On average, how many times do you awake during the night? _____ times. How long are you awake? _____
3. Workday bedtime: _____ Wakeup time: _____
4. Day off Bedtime: _____ Day off wakeup time: _____

Please answer these questions using our number scale; circle your choice:

	1 = rarely less than once a month	2 = sometimes 1-3 times a month	3 = often 4-8 times a month	4 = frequently 3-4 times a week	5 = always 5-7 times a week	
5. No matter how much I sleep I get, I wake up feeling tired:	No	1	2	3	4	5
6. If you were able to sleep longer would you feel rested?	No	1	2	3	4	5
7. So you have a problem with your work performance because you are sleepy or tired?	No	1	2	3	4	5
8. Have you fallen asleep at work?	No	1	2	3	4	5
9. Do you take regular naps?	No	1	2	3	4	5
10. Do you feel sleepy when driving?	No	1	2	3	4	5
11. Does your snoring disturb others?	No	1	2	3	4	5
12. Have you been told you hold your breath or gasp for air when sleeping?	No	1	2	3	4	5
13. I wake up short of breath or gaping?	No	1	2	3	4	5
14. I have a problem falling asleep and sleeping a full night?	No	1	2	3	4	5
15. My legs seem to move or kick during my sleep at night?	No	1	2	3	4	5
16. Do you clench or grind your teeth during the night?	No	1	2	3	4	5
17. Have you ever had a sleep study before?	No	1	2	3	4	5
18. Do you have relatives with sleep disorders?	No	1	2	3	4	5
19. Do you have and significant stress in your life at the present time?	No	1	2	3	4	5

I certify that the above information has been answered to the best of my ability.

Patient's signature _____ Date: _____