TRIKA MEDICAL INC.

BREATHE RIGHT, SLEEP THROUGH THE NIGHT

Dr. Anurag Sahai, MD, FCCP, FAASM

18095 HWY 18, STE B, Apple Valley Ca 92307, United States

Tele: 760-242-2333
Fax:7 60-242-2337

Patient Sleep Questionnaire

Name:______________________________ Date:______________

Address:____

Phone:______________ Work:______________ Cell:______________

Date of Birth:______________________ Sex: Male/ Female__________

Age:____________Height:____________ Weight:______________

Race (optional): ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Native American ☐Other

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Separated

Occupation:____

My Normal work hours per day are:__________________________

Weight Gain or loss (10lbs or more) ☐Yes ☐No if yes give details:__________

Health care professional who referred you to us for your sleep testing: (name of Doctor/Physician Assistant and specialty) :__________________

Medical History: ☐High Blood Pressure ☐Bypass surgery ☐Heart Attack ☐Congestive heart ☐Failure ☐Asthma ☐COPD (Emphysema, Bronchitis) ☐Hiatal hernia ☐Reflux ☐Stroke ☐Diabetes ☐Thyroid Disease ☐Tonsillectomy/ Adenoidectomy ☐Other

please specify:____

Have you had any recent surgeries? Please List:________________

The Following questions will help us understand more about you. These questions will also help the physician when they look at your sleep study. Please answer the questions as frankly as possible as they relate to the last 12 months (unless otherwise indicated) Do not leave any question unanswered. You may add comments to any of your answers in the margin beside the question. All Information Will be Kept Strictly Confidential

Main Complaint(s) is /are	I have been experiencing these symptoms for:				
○Snoring	○1-18 mos.	○19mos-5yrs	○6-10yrs	○11-20 yrs	○>20yrs
○My breathing stops	○1-18 mos.	○19mos-5yrs	○6-10yrs	○11-20 yrs	○>20yrs
○I am sleepy	○1-18 mos.	○19mos-5yrs	○6-10yrs	○11-20 yrs	○>20yrs
○I talk or walk in my sleep	○1-18 mos.	○19mos-5yrs	○6-10yrs	○11-20 yrs	○>20yrs
○I can't fall asleep	○1-18 mos.	○19mos-5yrs	○6-10yrs	○11-20 yrs	○>20yrs
○I can't stay asleep	○1-18 mos.	○19mos-5yrs	○6-10yrs	○11-20 yrs	○>20yrs

Other (please comment):_____________________________________

____

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How long does it usually take you to fall asleep? Minutes: ________ Hours: _________

On average how many times do you wake up during the night?___________________

How long are you awake?____

Work day bedtime:__________ Wake up time: _________Day Off bedtime:___________

Day Off Wake up time:______________

Answer the following questions using our number scale:

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 5-7times a week

Question							
No matter how much sleep I get I wake up feeling tired	No	Yes	1	2	3	4	5
If you were able to sleep longer would you feel rested	No	Yes	1	2	3	4	5
Do you have a problem with your performance at work because you are sleepy or tired?	No	Yes	1	2	3	4	5
Have you fallen asleep at work?	No	Yes	1	2	3	4	5
Do you take regular naps?	No	Yes	1	2	3	4	5
Have you fallen asleep while driving?	No	Yes	1	2	3	4	5
Does your snoring disturb others?	No	Yes	1	2	3	4	5
Have you been told you hold your breath or gasp for air during sleep?	No	Yes	1	2	3	4	5
I wake up short of breath or gasping	No	Yes	1	2	3	4	5
I have asthma attacks during sleep	No	Yes	1	2	3	4	5
I sweat excessively during sleep	No	Yes	1	2	3	4	5
I wake up in the morning with a headache	No	Yes	1	2	3	4	5
Do you snore more on your back or on your side?	No	Yes	1	2	3	4	5
I have problem falling asleep at night	No	Yes	1	2	3	4	5
I awaken because of aches pains and headaches	No	Yes	1	2	3	4	5
I have trouble going back to sleep if I wake up during the night	No	Yes	1	2	3	4	5
I have irresistible urges to fall asleep	No	Yes	1	2	3	4	5
I wake up absolutely unable to move	No	Yes	1	2	3	4	5
I have muscle weakness or fall asleep without warning brought on by laughter surprise or other strong emotion	No	Yes	1	2	3	4	5
I have a creeping crawling, restless feeling and desire to move my legs which keeps me from falling asleep. The discomfort is quickly relieved for the duration of the movements	No	Yes	1	2	3	4	5
My legs seem to kick rhythmically during sleep	No	Yes	1	2	3	4	5
I get frequent leg cramps	No	Yes	1	2	3	4	5
Do you act out your dreams?	No	Yes	1	2	3	4	5
Do you awaken screaming in fear or agitated?	No	Yes	1	2	3	4	5
Do you now or did you as a child wet the bed?	No	Yes	1	2	3	4	5
Have you been sleepwalker as an adult?	No	Yes	1	2	3	4	5
Do you have or are you treated for seizures in your sleep?	No	Yes	1	2	3	4	5
Do you grind your teeth during night?	No	Yes	1	2	3	4	5
Do you wear dentures?	No	Yes	1	2	3	4	5

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Please List your typical intake of the following:

List only caffeinated beverages:

Coffee:_____ cups per day **Tea:**____ cups per day **Soda:**_____ glasses per day

Other:______Beer cans /day **Liquor:**______ shots/day **Wine:** ____glasses per day

Cigarettes:______ per day **Cigars:**______ per day

Have you ever had a sleep study before?___Yes___ No if yes, specify

Result of the study:____

Do you have any relatives with sleep disorders? ___Yes___ No if yes, specify

Do you have significant stress in your life at the present time.___Yes___No

If yes please explain:____

Are you allergic to any medications that you are aware of ?___Yes___No

If yes what?____

Please list your medications both prescription and over the counter

Medication	What For	How often