

YOUR NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_

Describe your sleep problem and how long you've had it \_\_\_\_\_

Have you ever been at a sleep center before? YES\_\_\_ NO\_\_\_ When? \_\_\_\_\_

Where? \_\_\_\_\_ Ever been on CPAP? YES\_\_\_ NO\_\_\_

**WORK SCHEDULE** When does your usual work shift start? \_\_\_\_\_ AM or PM

When does your usual work shift end? \_\_\_\_\_ AM or PM Do you do shift work? YES\_\_\_ NO\_\_\_

**SLEEP SCHEDULE**

	<u>Weekday</u>	<u>Weekend</u>		<u>Weekday</u>	<u>Weekend</u>
Time You Go To Bed	_____	_____	Time You Get Up	_____	_____
How long does it take you to go to sleep?	_____ hrs/min		How often do you wake during the night?	_____	
How many hours do you sleep each night?	_____ Average _____		Minimum (hrs)	_____	Maximum (hrs) _____
Do you take naps? YES___ NO___	How many days per week? _____		On the average, how long are the naps?	_____ hrs.	

**EPWORTH SLEEPINESS SCALE**

How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life recently. Even if you have not done some of these things recently, try to answer how they would affect you. Use the following scale to choose the most appropriate number for each situation:

- |                                    |                                      |
|------------------------------------|--------------------------------------|
| 0 = would <b>NEVER</b> doze        | 2 = <b>MODERATE</b> chance of dozing |
| 1 = <b>SLIGHT</b> chance of dozing | 3 = <b>HIGH</b> chance of dozing     |

**Situation**

Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place, such as a meeting or church	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you have not had alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3
<b>Total</b>				

**BED PARTNER QUESTIONNAIRE** Ask someone familiar with your sleep to answer the following section about you (spouse, parent, etc.)

Name of person filling out this section \_\_\_\_\_

Does the patient ...	Circle Your Answer Below			
Stop breathing in his/her sleep?	Yes		No	
How often do the pauses in breathing occur?	Every Night		Occasionally Multiple times per night	
Snore Heavily?	Yes		No	
Snore Continuously?	Yes		No	
Snore Every Night?	Yes		No	
Snore in the following positions:	Back	Left Side	Right Side	All Positions
Kick and Jerk Frequently	Yes		No	
Sleep Walk or Talk During Sleep?	Yes		No	

Comments \_\_\_\_\_

**OTHER ILLNESSES** Circle All That Apply

Diabetes	High Blood Pressure	Emphysema	High Cholesterol
Coronary Artery Disease	Irregular Heart Beats	Stroke	Ulcers/ Reflux
Depression	Anxiety	Thyroid Disease	Kidney Disease
Chronic Nasal Congestion	Cancer	Migraines	Cataracts
Other _____			

**SURGICAL HISTORY** Circle All That Apply

Appendectomy	Cardiac Bypass	Gall Bladder	Hysterectomy
Tonsils & Adenoids	Nose or Sinuses	Other _____	
Other _____		Other _____	

**TOBACCO** Ever smoked? YES \_\_\_ NO \_\_\_ If yes, how long? \_\_\_\_\_ Packs per day \_\_\_\_\_  
 Do you still smoke? YES \_\_\_ NO \_\_\_ When did you quit? \_\_\_\_\_

**ALCOHOL/DRUGS** Do you drink alcohol? YES \_\_\_\_\_ NO \_\_\_\_\_  
 If yes, how often? \_\_\_\_\_ days/wk How much on the average? \_\_\_\_\_  
 Have you ever had a problem with drinking too much alcohol? YES \_\_\_ NO \_\_\_\_\_

**CAFFEINE and OTHER SUBSTANCES**

Regular coffee \_\_\_\_\_ cups/day Decaffeinated coffee \_\_\_\_\_ cups/day  
 Soft drinks with caffeine? YES \_\_\_ NO \_\_\_ If yes, How Many? \_\_\_\_\_ per day  
 Do you drink tea with caffeine? YES \_\_\_ NO \_\_\_ If yes, how many cups/glasses \_\_\_\_\_ per day  
 Do you currently use street drugs? YES \_\_\_ NO \_\_\_\_\_

**MEALS/ EXERCISE** How many meals do you eat daily? \_\_\_\_\_ Do you exercise regularly? YES \_\_\_ NO \_\_\_

**FAMILY HISTORY** Circle the Condition and then List Affected Family Members

CONDITION	AFFECTED FAMILY MEMBER	CONDITION	AFFECTED FAMILY MEMBER
Diabetes	_____	Narcolepsy	_____
Heart Disease	_____	Daytime Sleepiness	_____
High Blood Pressure	_____	Depression	_____
Stroke	_____	Anxiety	_____
Obesity	_____	Sleep Apnea	_____
Other - Describe	_____		
Other - Describe	_____		

Sensory Impairments (Check all that apply)			Communication		
Note					
<i>Vision</i>		<i>Hearing</i>	<i>Understands English</i>	Y	N
Normal		Normal	Primary Language		
Glasses		Decreased	Able to read	Y	N
Contacts		Hearing Devices	Able to print/write	Y	N
Blind		Deaf	(*Obtain interpreter if needed)		

## SLEEP REVIEW OF SYSTEMS

### DROWSINESS/SLEEPINESS

Are you frequently fatigued or drowsy during the day? YES\_\_\_ NO\_\_\_  
Have you had any accidents at work due to sleepiness? YES\_\_\_ NO\_\_\_  
Have you had any near traffic accidents due to sleepiness? YES\_\_\_ NO\_\_\_

### SNORING

Has anyone told you that you snore loudly? YES\_\_\_ NO\_\_\_  
Do you snore every night? YES\_\_\_ NO\_\_\_  
Do you snore almost continuously? YES\_\_\_ NO\_\_\_  
Have you awakened with a dry "cotton mouth"? YES\_\_\_ NO\_\_\_  
Has anyone told you that you quit breathing or hold your breath at night? YES\_\_\_ NO\_\_\_  
Have you ever awakened gasping for breath? YES\_\_\_ NO\_\_\_  
Do you ever wake at night with coughing, choking, or respiratory discomfort? YES\_\_\_ NO\_\_\_  
Do you have a dry throat when you wake up in the morning? YES\_\_\_ NO\_\_\_  
Do you have trouble breathing through your nose at night? YES\_\_\_ NO\_\_\_  
Do you have trouble breathing through your nose during the day? YES\_\_\_ NO\_\_\_  
Do you have morning headaches? YES\_\_\_ NO\_\_\_  
Weight change last 5 years → Gained \_\_\_\_\_ lbs. or Lost \_\_\_\_\_ lbs.

### REFLUX

Do you often wake with a sour taste or a burning sensation in your chest? YES\_\_\_ NO\_\_\_

### EXCESSIVE DAYTIME SOMNOLENCE

Do you have sudden episodes of sleep during the day? YES\_\_\_ NO\_\_\_  
Have you ever had periods in which you feel paralyzed while going to sleep or waking up? YES\_\_\_ NO\_\_\_  
Have you ever had visual hallucinations or dream-like mental images when falling to sleep? YES\_\_\_ NO\_\_\_  
Have you ever experienced sudden physical weakness during strong emotions?  
(such as your mouth dropping open or legs going limp during laughter or anger) YES\_\_\_ NO\_\_\_

### CHILDHOOD

Did you have childhood sleep problems of any type? YES\_\_\_ NO\_\_\_

If Yes Describe \_\_\_\_\_

### RESTLESS LEGS SYNDROME/ PERIODIC LIMB MOVEMENT DISORDER

Do you frequently kick and jerk your legs at night while trying to fall asleep? YES\_\_\_ NO\_\_\_  
Do you have discomfort in your legs while trying to fall asleep? YES\_\_\_ NO\_\_\_  
Does moving your legs give you relief of discomfort? YES\_\_\_ NO\_\_\_  
Do you have tingling or discomfort in your legs during the day? YES\_\_\_ NO\_\_\_  
Do you have discomfort in your legs when sitting for long periods? YES\_\_\_ NO\_\_\_

### INSOMNIA

Do you have difficulty initiating sleep at night? YES\_\_\_ NO\_\_\_  
Do you have difficulty staying asleep at night? YES\_\_\_ NO\_\_\_  
Do you have pain that bothers you at night? YES\_\_\_ NO\_\_\_

### PARASOMNIAS

Do you sleep walk? YES\_\_\_ NO\_\_\_  
Do you wet the bed at night? YES\_\_\_ NO\_\_\_ Do you talk in your sleep? YES\_\_\_ NO\_\_\_  
Do you ever wake up screaming? YES\_\_\_ NO\_\_\_ Do you have frequent nightmares? YES\_\_\_ NO\_\_\_  
Do you grind your teeth in your sleep? YES\_\_\_ NO\_\_\_

## Review of Systems

Circle any symptoms that you have

<b>EYES</b>	BLURRY VISION	LOSS OF VISION	DOUBLE VISION	EYE PAIN	DRY EYES
<b>EAR, NOSE &amp; THROAT</b>	HEARING LOSS	RINGING	EAR PAIN	SORE THROAT	DRY MOUTH
<b>HEART</b>	CHEST PAIN	HEAVINESS	RACING OR POUNDING		
<b>PULMONARY</b>	SHORT OF BREATH	WHEEZING	COUGH	COUGHING UP BLOOD	PHLEGM
<b>STOMACH &amp; GI TRACT</b>	NAUSEA VOMITTING	TROUBLE SWALLOWING DIARRHEA	STOOLS BLACK AS TAR CONSTIPATION	BRIGHT BLOOD IN STOOLS STOMACH PAIN	HEART BURN
<b>GENITOURINARY</b>	URINE WITH COUGH BURNING	INCONTINENCE DRIBBLING URINE	TROUBLE EMPTYING THE BLADDER SEXUAL PROBLEMS	BLOOD IN URINE	FREQUENT URINATION
<b>MUSCLE/SKELETAL</b>	BACK PAIN TWITCHING MUSCLES	NECK PAIN ARM OR LEG PAIN	SORE MUSCLES STIFFNESS	SWOLLEN JOINTS	CRAMPS
<b>SKIN</b>	ITCHING	RASH	BLISTERS	PEELING	DRY SKIN
<b>NEUROLOGIC</b>	WEAKNESS LIGHT HEADEDNESS SHAKING TREMOR	NUMBNESS IMBALANCE JERKING	TINGLING FORGETFULNESS	INCOORDINATION HEADACHE	DIZZINESS SLURRED SPEECH
<b>PSYCHOLOGICAL</b>	PERSONALITY CHANGE IRRITABLE	LOSS OF INTEREST DEPRESSED	ANGRY CRYING SPELLS	SAD NERVOUS	WITHDRAWN SUICIDAL THOUGHTS
<b>ENDOCRINE</b>	FREQUENT THIRST	ALWAYS COLD	ALWAYS HOT		
<b>HEMATOLOGIC</b>	BRUISING	BLEEDING EASILY	SWOLLEN GLANDS		
<b>ALLERGY</b>	BURNING EYES	RUNNY NOSE	CHEMICAL SENSITIVITY		
<b>CONSTITUTIONAL</b>	FATIGUE	FEVER	NIGHT SWEATS	SHAKING CHILLS	LOSS OF APPETITE

## MEDICATIONS/ALLERGIES

List any medication allergies \_\_\_\_\_

### List your medications (including vitamins and over the counter medications)

NAME	SIZE (MG)	HOW YOU TAKE IT (Ex: 3 TIMES A DAY)
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____
6 _____	_____	_____
7 _____	_____	_____
8 _____	_____	_____
9 _____	_____	_____
10 _____	_____	_____
11 _____	_____	_____
12 _____	_____	_____

# PATIENT DEMOGRAPHICS

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone: HOME: (\_\_\_\_) \_\_\_\_\_ WORK: (\_\_\_\_) \_\_\_\_\_ CELL: (\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Occupation: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

Marital Status (circle one):    Married    Single    Widowed    Divorced    Separated

#Children \_\_\_\_\_

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Emergency Contact (other than spouse):

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship (circle one):    Parent    Spouse    Child    Sibling    Friend    Other Relative

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Referring Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Family Doctor (if different from referring physician): \_\_\_\_\_ Phone #: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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Primary Insurance: \_\_\_\_\_ Phone #: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Phone #: \_\_\_\_\_

ID# \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_