

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 Weekday Weekend Weekday Weekend

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 **NEVER** doze
- 1 = **SLIGHT** chance of dozing
- 2 = **MODERATE** chance of dozing
- 3 = **HIGH** 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
Total				

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					
Vision		Hearing	Understands English	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

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PSYCHOLOGICAL	PERSONALITY CHANGE IRRITABLE	LOSS OF INTEREST DEPRESSED	ANGRY CRYING SPELLS	SAD NERVOUS	WITHDRAWN SUICIDAL THOUGHTS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

Date of Birth: _____ Social Security #: _____

Street Address: _____ City: _____ State: ____ ZIP: _____

Occupation: _____ Name of Employer: _____

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

How many children (if any): _____

.....
Emergency Contact (other than spouse):

Last Name: _____ First Name: _____ Phone Number: _____

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

.....
Referring Physician: _____ Phone#: _____

Street Address: _____ City: _____ State: ____ Zip: _____

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

Street Address: _____ City: _____ State: ____ Zip: _____

.....
Primary Insurance: _____ Phone #: _____

ID#: _____ Group #: _____

Subscriber's Name: _____ Date of Birth: _____

Secondary Insurance: _____ Phone #: _____

ID# _____ Group #: _____

Subscriber's Name: _____ Date of Birth: _____