

SLEEP MEDICINE HISTORY FORM

Name: _____ Today's Date: _____

DOB: _____ Sex: M / F Weight: _____ lbs Height: _____ ft _____ in

Primary Care Provider: _____ Collar size (inches): _____

SLEEP ROUTINE:

1. What TIME do you GO TO BED? _____
2. How long does it take for you to fall asleep? _____
What occurs during that time? _____
3. Do you frequently wake up in the middle of the night? YES/NO
 a. If YES, how many times? _____
 b. What is the reason for waking up during the night? _____
 c. How long does it take you to return to sleep? _____
4. What TIME do you WAKE UP in the morning? _____
5. Do you feel REFRESHED UPON WAKING UP? YES/NO
6. Do you take any
 - a. Scheduled/Planned Naps YES/NO When _____ How Long _____
 - b. Unscheduled/Unplanned Naps? YES/NO
 _____ When driving
 _____ When inactive
 _____ In conversations
 - c. IF YES, Do you feel refreshed after the nap? YES/NO
7. Any change in sleep schedule on your DAYS OFF? _____
8. Have you recently had any change in your WEIGHT in the PAST 3 YEARS? GAINED/LOST How much? _____

SLEEP APNEA SYMPTOMS:

9. Has anyone told you that you SNORE? YES/NO
 a. If YES, How LOUD? MILD/ MODERATE/ LOUD/ VERY LOUD
 Has anyone seen you STOP BREATHING or YES/NO
 have pauses in breathing when you sleep?
10. Do you wake-up from sleep with a CHOKING/GAGGING sensation? YES/NO
11. Has anyone told you that you MAKE SNORTING/GASPING noises in sleep? YES/NO
12. Do you wake up with a DRY MOUTH? YES/NO
13. Do you wake up with a HEADACHE? YES/NO
14. Do you DROOL on the pillow? YES/NO
15. Do you feel TIRED during the day? NO/ Mild/ Moderate/ Severe

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RESTLESS LEGS:

16. Do you have UNCOMFORTABLE SENSATIONS YES/NO
in your legs before bedtime?
17. If YES, please describe them? _____
18. Do you have any of the following during sleep?
- a. SLEEPWALKING YES/NO
 - b. SLEEP TALKING YES/NO
 - c. NIGHTMARES YES/NO
 - d. ACTING OUT DREAMS YES/NO

SLEEP HYGIENE:

1. Do you do any of these activities in your bed/bedroom?
- a. WATCH TV YES/NO
 - b. EAT YES/NO
 - c. READ YES/NO
2. Do you drink coffee/caffeinated beverages? Never/Occasional/Moderate
3. SMOKING Never/Former/Current
4. Do you drink ALCOHOL? Never/Occasional/Moderate
5. Do you use illicit drugs? YES/NO Type _____

MISCELLANEOUS:

1. When FALLING ASLEEP or WAKING UP
- a. Do you ever SEE or HEAR things? YES/NO
If YES, DESCRIBE _____
 - b. Do you ever FEEL PARALYZED? YES/NO
2. Do you ever feel SUDDEN MUSCLE WEAKNESS YES/NO
when you are laughing?

DRUG ALLERGIES: Check box if no known allergies to any medications .

- a. Drug name _____ - What Reaction? _____
- b. Drug name _____ - What Reaction? _____
- c. Drug name _____ - What Reaction? _____

FAMILY HISTORY:

1. Does anyone in your family have sleep apnea? YES/NO
- a. If YES, who? _____

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CURRENT MEDICATIONS: Please list all of your current medications:

Have you ever had a SLEEP STUDY before? NO/YES where? _____

PAST MEDICAL HISTORY

- Hypertension (high blood pressure)
- Heart attack
- Cardiac arrhythmias
- Atrial fibrillation
- Lung problems / COPD / Asthma
- Parkinson's disease
- Arthritis
- Depression / anxiety / bipolar
- Pacemaker
- Other: _____
- Nasal allergies / nasal congestion
- Congestive heart failure
- Stroke / TIA
- Pulmonary hypertension
- Anemia / iron deficiency
- Seizures
- Autoimmune disease
- End stage kidney disease / dialysis
- Chronic Pain (reason) _____
- Thyroid disease
- Diabetes
- Heartburn / reflux
- Fibromyalgia
- Menopause
- Cancer
- Broken nose
- Head injury

SURGERIES:

Please list all your surgeries

REVIEW OF SYSTEMS: Check the symptoms you frequently experience:

- Const: Fever Feeling poorly Feeling tired Chills
- ENT: Ear pain Frequent nosebleeds Sore throat Hearing loss Nasal discharge
 Hoarseness lasting more than 2 weeks Nasal congestion
- Heart: Passing out Chest pain, tightness or pressure Irregular heartbeat
 Palpitations Swelling of feet/ ankles
- Resp: Shortness of breath Frequent cough for more than 2 weeks
 Wheezing
- GI: Abdominal pain Difficulty swallowing/ food "sticking" Frequent heartburn/ indigestion
 Constipation Diarrhea Nausea Vomiting
- MSK: Joint pain Joint swelling Joint stiffness Limb pain Limb swelling
 Muscle pain Back pain
- Neuro: Frequent headaches Seizures Numbness/tingling Weakness
 Ringing in ear(s)
- Behav: Anxiety Change in personality Sleep disturbance Depression
- Hema: Swollen glands Easy bleeding Easy bruising
- GU: Nocturia Incontinence Sexual dysfunction/loss of libido



EPWORTH SLEEPINESS SCALE FORM

NAME _____ DOB _____ DATE _____

The test is a list of eight situations in which you rate your tendency to become Sleepy

Instructions: Be as truthful as possible.

Write down the number corresponding to your choice in the right hand column. Total your score below.

No chance of dozing =0

Slight chance of dozing =1

Moderate chance of dozing =2

High chance of dozing =3

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g., a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Total Score = _____