Northern Arizona Healthcare
Flagstaff Medical Center • Verde Valley Medical Center

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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 have pauses in breathing when you sleep? YES/NO
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

SLEEP MEDICINE HISTORY FORM

RESTLESS LEGS:

16. Do you have UNCOMFORTABLE SENSATIONS in your legs before bedtime? YES/NO
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 when you are laughing? YES/NO

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

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? _____

SLEEP MEDICINE HISTORY FORM

CURRENT MEDICATIONS: Please list all of your current medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

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

PAST MEDICAL HISTORY

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

o Other: _____

SURGERIES:

Please list all your surgeries

_____

_____

_____

REVIEW OF SYSTEMS: Check the symptoms you frequently experience:

Const: o Fever o Feeling poorly o Feeling tired o Chills

ENT: o Ear pain o Frequent nosebleeds o Sore throat o Hearing loss o Nasal discharge o Hoarseness lasting more than 2 weeks o Nasal congestion

Heart: o Passing out o Chest pain, tightness or pressure o irregular heartbeat o Palpitations o Swelling of feet/ ankles

Resp: o Shortness of breath o Frequent cough for more than 2 weeks o Wheezing

GI: o Abdominal pain o Difficulty swallowing/ food "sticking" o Frequent heartburn/ indigestion o Constipation o Diarrhea o Nausea o Vomiting

MSK: o Joint pain o Joint swelling o Joint stiffness o Limb pain o Limb swelling o Muscle pain o Back pain

Neuro: o Frequent headaches o Seizures o Numbness/tingling o Weakness o Ringing in ear(s)

Behav: o Anxiety o Change in personality o Sleep disturbance o Depression

Hema: o Swollen glands o Easy bleeding o Easy bruising

GU: o Nocturia o Incontinence o Sexual dysfunction/loss of libido

NORTHERN ARIZONA HEALTHCARE

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 = _____