

## SLEEP MEDICINE HISTORY FORM

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: M / F Weight: \_\_\_\_\_ lbs Height: \_\_\_\_\_ ft \_\_\_\_\_ in

Primary Care Provider: \_\_\_\_\_ Collar size (inches): \_\_\_\_\_

- Do you use supplemental oxygen? YES/NO  
If Yes, how much? \_\_\_\_\_

### SLEEP DISORDERS SIGNS & SYMPTOMS:

- |  |                                 |
|--|---------------------------------|
| 1. Do you SNORE?   | YES/NO                          |
| a. If YES, How LOUD?   | MILD/ MODERATE/ LOUD/ VERY LOUD |
| 2. Has anyone told you that sometimes you STOP/PAUSE your BREATHING when you sleep?                  | YES/NO                          |
| 3. Has anyone told you that you  |                                 |
| 4. MAKE SNORTING/GASPING noises in sleep?  | YES/NO                          |
| 5. Do you wake-up from sleep with a CHOKING/GAGGING sensation?                                       | YES/NO                          |
| 6. Do you wake up with a DRY MOUTH?  | YES/NO                          |
| 7. Do you wake up with a HEADACHE?   | YES/NO                          |
| 8. Do you experience TEETH GRINDING or clenching?  | YES/NO                          |
| 9. Do you feel TIRED during the day?   | NO/ Mild/ Moderate/ Severe      |
| 10. Do you ever feel the need to move your legs in bed?  | YES/NO                          |
| a. Does anything make this better? (walking, meds)   | YES/NO                          |
| 11. Do you experience sleep walking/talking?   | YES/NO                          |
| 12. Has anybody told you that you ACT YOUR DREAMS?<br>(yelling or flailing your arms in your sleep)? | YES/NO                          |

### SLEEP ROUTINE:

- |   |       |
|---|-------|
| 13. What TIME do you GO TO BED?                   | _____ |
| 14. What TIME do you WAKE UP in the morning?      | _____ |
| 15. How long does it take for you to fall asleep? |       |

# SLEEP MEDICINE HISTORY FORM

16. 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? \_\_\_\_\_
17. Do you feel REFRESHED or RESTED UPON WAKING UP? YES/NO
18. Do you take any naps? YES/NO When\_\_\_\_How Long\_\_\_\_
19. Any change in sleep schedule on your DAYS OFF? \_\_\_\_\_
20. Have you recently had any change in your WEIGHT in the PAST 3 YEARS? GAINED/LOST How much? \_\_\_\_\_

## SLEEP HYGIENE:

1. Does your partner sleep in the same bed? YES/NO
2. Does your pet jump in your bed at night? YES/NO
3. Do you take any meds or supplements for sleep? YES/NO
4. Do you drink coffee/caffeinated beverages? Never/Occasional/Moderate  
a. At around what time is your last caffeine intake? \_\_\_\_\_
5. SMOKING Never/Former/Current
6. Do you drink ALCOHOL? Never/Occasional/Moderate
7. Do you use other recreational substances? YES/NO Type\_\_\_\_\_

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

## FAMILY HISTORY:

1. Does anyone in your family have any sleep disorders (sleep apnea, insomnia)? YES/NO  
a. If YES, who? \_\_\_\_\_

## 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? \_\_\_\_\_

# SLEEP MEDICINE HISTORY FORM

**CURRENT MEDICATIONS:** Please list all of your current medications:

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## 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

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**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



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 = \_\_\_\_\_