Patient Name: _____ **DOB:** _____

Sleep History

1. **What is your sleep difficulty?**

2. **When did your sleep difficulty FIRST occur?**

3. **How often does it happen?**

4. **Have you had a prior sleep study? (Circle below)**

Date of Last Study, if applicable:

Overnight PSG	No	Yes
Overnight PSG with CPAP (Titration)	No	Yes
Overnight PSG with MSLT the Next Day	No	Yes
Home Sleep Test	No	Yes

5. **What have you done to treat your sleep problem?**

Please rate yourself to degree or the frequency that you are bothered by a particular complaint or problem listed below: (Please circle below)

6. Do you DOZE OFF during the daytime when you are STILL or not busy? Often Occasional Never

7. Do you awaken feeling UNREFRESHED, SLEEPY, GROGGY even after plenty of sleep? Often Occasional Never

8. Do you suffer from FATIGUE or tiredness during the day? Often Occasional Never

---

9. Do you have LOUD or DISRUPTIVE SNORING? Often Occasional Never

10. Has a family member or bed partner OBSERVED you STOP BREATHING or GASP in sleep? Often Occasional Never

11. Do you have OTHER BREATHING PROBLEMS in sleep? If so, elaborate below. Often Occasional Never

12. Do you suffer from headaches? Often Occasional Never

If Yes, then select all that applies:

- ❒ Upon Waking
- ❒ Later in the Day

13. Do you awaken with HEARTBURN or stomach acid in the mouth? Often Occasional Never

14. Do you typically awaken in the night to URINATE? Often Occasional Never

If Yes, then how many times?

---

15. Do you have a problem GETTING to sleep? Often Occasional Never

16. Do you WAKE UP FREQUENTLY in the night? Often Occasional Never

17. Are you RESTLESS in the LEGS BEFORE SLEEP or have “creepy, tingling” sensations? Often Occasional Never

18. Do you MOVE OFTEN IN SLEEP, or wake with RESTLESS LEGS OR LEG CRAMPS? Often Occasional Never

19. Has a family member or bedpartner noted that your LEGS TWITCH or KICK in your sleep? Often Occasional Never

---

20. Do you wake up feeling completely PARALYZED or "stuck" awakening from sleep? Often Occasional Never

21. Do you HALLUCINATE from sleep? Often Occasional Never

22. Do you have episodes of MUSCULAR WEAKNESS with laughing or when emotional? Often Occasional Never

---

23. Do you have any OTHER UNUSUAL BEHAVIORS in your sleep? Often Occasional Never

❒ Walking ❒ Screaming Out ❒ Nightmares ❒ Eating ❒ Confusion

❒ Other

24. Do you GRIND TEETH in sleep? Often Occasional Never

25. What are your typical sleep times during the WORK WEEK?

A. What time do you usually go to bed? _____

B. How long does it usually take you to fall asleep after deciding to go to sleep? _____

C. How many times do you wake up during a typical night? _____

D. What time do you usually arise for the day? _____

E. What is your average hours of sleep time per night? _____

F. On DAYS OFF, do you CHANGE YOUR SLEEP ROUTINE? (If yes, please explain)

G. Do you take NAPS? (Circle) No Yes

If Yes, then how many times per week? _____

If Yes, then for what duration of time? _____

Past Medical History

Your TYPICAL nightly sleeping position(s): (Circle) Side Stomach Back Elevated

Height (inches):_____ **Weight (lbs):** _____

Lifetime Maximum Weight (lbs): _____

In the last 12 month how many pounds have you gained or lost?

Have your ever smoked? No Yes

# of Packs: _____ # of Years: _____

New Patient - All Providers

Personal Medical History: Conditions - current or treated in the past. (Check all that apply)

- ❒ Allergies
- ❒ Anemia
- ❒ Anxiety
- ❒ Arthritis
- ❒ Asthma
- ❒ Benign Prostatic Hyperplasia
- ❒ Bipolar Disorder
- ❒ Blood Clot
- ❒ Cancer (add comments below)
- ❒ Chronic Fatigue
- ❒ Congestive Heart Failure
- ❒ COPD / Breathing Problems
- ❒ Coronary Artery Disease
- ❒ Cataracts
- ❒ Dementia / Memory Loss
- ❒ Depression
- ❒ Diabetes
- ❒ Diverticulosis
- ❒ Eating Disorder
- ❒ Emphysema
- ❒ Fibromyalgia
- ❒ Other
- ❒ None
- ❒ Glaucoma
- ❒ Gout
- ❒ Heart Attack
- ❒ Heart Disease
- ❒ Heartburn / Gastric Reflux
- ❒ Hepatitis
- ❒ High Cholesterol
- ❒ HIV
- ❒ Hypertension
- ❒ Kidney Disease
- ❒ Kidney Stones
- ❒ Leg / Foot Ulcers
- ❒ Liver Disease
- ❒ Obesity
- ❒ Osteoporosis
- ❒ Pneumonia
- ❒ Seizures
- ❒ Stroke
- ❒ Thyroid Disease
- ❒ Tuberculosis
- ❒ Ulcers
- ❒ Urinary Tract Infections

Briefly explain each Issue selected: (If none, please type "No personal medical history"

List the type and amounts of substances that you consume routinely

Beverages	**Weekly**	**After 6pm**
Caffeinated coffee (12 oz cups)	_____	_____
Caffeinated soft drinks / tea / Energy drinks (12 oz servings)	_____	_____
Beer, wine, liquor (#cans/drinks)	_____	_____
Recreation Drugs (# of occasions)	_____	_____

CURRENT Medications

If you are currently not taking any medications, check box! ❒

Please list all medications that you are currently taking (prescribed or otherwise): Include Over The Counter

Requested Format. ....Name of Medication, Dosage, Frequency, Reason and side effect (if any)

Example. ....Zestril, 20mg, Once per Day, Hypertension, Sometimes a headache

Please use a separate line for each medication.....

PRIOR SLEEP Medications

List all prior sleep medications that you have taken in the past but are no longer taking for your sleep problems, please including those prescribed as well as herbal, holistic, or natural medications and over the counter medications.

Requested Format. ....Name of Medication, Dosage, Frequency, Reason and side effect (if any)

Example. ....Lunesta, 3mg, At Bedtime, Insomnia, Sometimes nausea and dizziness

Please use a separate line for each medication.....

Prior reactions to ANY medications? ❒ Yes ❒ No

Social History

Current Marital Status: (Circle) Singled Married Divorced Widowed

Do you have any children? (Circle) None 1 2 3 4 5 6 7 8 8+

Employment Status: (Circle) Employed Not Employed Retired

What do you / did you do for a living?

Family Medical History

For each family member, please select and breifly describe any known medical and/or sleep difficulties, such as snoring, apnea, insomnia, narcolepsy, restless less.

Natural Blood Relatives - General Medical Issues

	Mother	Father	Sister	Brother	Daughter	Son
Arthritis	❒	❒	❒	❒	❒	❒
Asthma	❒	❒	❒	❒	❒	❒
Cancer	❒	❒	❒	❒	❒	❒
Dementia	❒	❒	❒	❒	❒	❒
Depression	❒	❒	❒	❒	❒	❒
Diabetes - Type I	❒	❒	❒	❒	❒	❒
Diabetes - Type II	❒	❒	❒	❒	❒	❒
Heart Disease	❒	❒	❒	❒	❒	❒
High Blood Pressure	❒	❒	❒	❒	❒	❒
High Cholesterol	❒	❒	❒	❒	❒	❒
Kidney Disease	❒	❒	❒	❒	❒	❒
Obesity	❒	❒	❒	❒	❒	❒
Osteoporosis	❒	❒	❒	❒	❒	❒
Stroke	❒	❒	❒	❒	❒	❒
Substance Abuse	❒	❒	❒	❒	❒	❒

Natural Blood Relatives - Sleep Specific Issues

	Mother	Father	Sister	Brother	Daughter	Son
Apnea - Sleep Apnea	❒	❒	❒	❒	❒	❒
Circadian Rhythm Disorders	❒	❒	❒	❒	❒	❒
Insomnia	❒	❒	❒	❒	❒	❒
Narcolepsy	❒	❒	❒	❒	❒	❒
Parasomnias	❒	❒	❒	❒	❒	❒
Restless Legs / PLMD	❒	❒	❒	❒	❒	❒
Sleep Movement Disorders	❒	❒	❒	❒	❒	❒

Briefly explain each General or Sleep Specific Issue selected: (If none, please type "No known family medical history"

Current Treating Physicians

Primary Care Physician (s)

Name	Address	Phone
Name	Address	Phone

Other Treating Physician (s)

Name	Address	Phone
Name	Address	Phone
Name	Address	Phone

Epworth Sleepiness Scale

In contract to just feeling tired, please rate how likely you are to doze off or fall asleep in the following situations. Please use the following scale provide:

0	NEVER dose	2	MODERATE chance of dozing off
1	SLIGHT chance of dozing off	3	HIGH chance of dozing off

	Morning (before noon)	**Afternoon (Noon-6pm)**	**Evening (after 6pm)**
Sitting & Reading	0 1 2 3	0 1 2 3	0 1 2 3
Watching TV	0 1 2 3	0 1 2 3	0 1 2 3
Sitting inactive in a public place	0 1 2 3	0 1 2 3	0 1 2 3
As a car passenger for an hour without a break	0 1 2 3	0 1 2 3	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3	0 1 2 3	0 1 2 3
Sitting & talking to someone	0 1 2 3	0 1 2 3	0 1 2 3
Sitting quitely after lunch without alcohol	0 1 2 3	0 1 2 3	0 1 2 3
In a car while stopped for a few minutes in traffic	0 1 2 3	0 1 2 3	0 1 2 3
Total Score	_____	_____	_____

Bed Partner Questionnaire

Please ask someone who has watched you sleep to complete this form

Patient's Name: _____

Obeserver's Name:_____

Relationship to Patient: _____

Select the most appropriate answer:	Once or Twice	Often	Almost Every Night
I have observed this patient's sleep....	❒	❒	❒

Check any of the following behaviors that that you have observed this person doing while asleep. Circle those that you consider severe problems for this person

- ❒ Light Snoring
- ❒ Loud Snoring
- ❒ Loud Snorts
- ❒ Choking
- ❒ Pause in breathing
- ❒ Gasping for air

If so, for how long?

- ❒ Twitching or kicking legs
- ❒ Twitching or flinging of arms
- ❒ Sleep Talking
- ❒ Grinding teeth
- ❒ Bed-Wetting
- ❒ Sitting up in bed not awake
- ❒ Awakening with pain
- ❒ Head rocking or banging
- ❒ Getting out of bed not awake
- ❒ Biting tongue
- ❒ Becoming very rigid and/or shaking
- ❒ Crying Out
- ❒ Apparently sleeping even if behaves otherwise

❒ **Other:**

❒ **Please List all the ones you believe are severe problems**

If this person snores, what makes it worse?

- ❒ Sleeping on back
- ❒ Alcohol Usage
- ❒ Sleeping on side
- ❒ Fatigue

Does the snoring sometimes require you or your partner to sleep separately?

❒ Yes ❒ No

MODIFIED Epworth Sleepiness Scale

As an observer, please complete the following information on your estimation of the chances of his/her dozing in the following situations. (Even if none of these things have occurred recently, try to work out how they would have affected him/her). Use the scale below to choose the most appropriate number for each situation:

0	NEVER dose
1	SLIGHT chance of dozing off
2	MODERATE chance of dozing off
3	HIGH chance of dozing off

	SCORE
Sitting & Reading	0 1 2 3
Watching TV	0 1 2 3
Sitting inactive in a public place	0 1 2 3
As a car passenger for an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting & talking to someone	0 1 2 3
Sitting quitely after lunch without alcohol	0 1 2 3
In a car while stopped for a few minutes in traffic	0 1 2 3

Total Score: _____

Does this person drink alcohol? ❒ Yes ❒ No

If yes, check all you believe is appropriate:

❒ Beer ❒ Wine ❒ Shots of Liquor

Estimate of how many 12 oz. bottle/can/tap BEER per week

Estimate of how many 6-8 oz glasses of WINE per week

Estimate of how many 1-12 oz. LIQUOR per week

Please estimate how much this person drinks in the 3 hours before bed

Do you consider this person's drinking a problem? ❒ Yes ❒ No ❒ Uncertain

Comments:

If this person uses street drugs, please describe both the types and frequency of usage:

Do you believe that this person and yourself share the same understanding about his/her sleep problem, sleeping pill usage, and alcohol/drug usage?

❒ Yes ❒ No

Final Comments: