Name: _____ Age: ____ Date: _____ Ref. Dr.: _____

Please help us find out about you by filling out the "Patient" side of this form on pages 1-3.

Please leave "Clinician" side blank.

PATIENT

CLINICIAN

Why are you here to see a sleep specialist?

_____

_____

CC

Do you snore?

□ Yes □ No □ Don't know

If yes, is it loud?

□ Yes □ No □ Don't know

HPI

How long ago did it start? _____

Is it worsening?

□ Yes □ No

In which position do you snore?

□ Back only

□ All positions

Is it worse on your back?

□ Yes □ No

Do you snore if you fall asleep in a chair?

□ Yes □ No

Does it disturb anyone?

□ Yes □ No

Who? _____

Has anyone ever noticed if you stop breathing while snoring?

□ Yes □ No

Do you gasp or choke while you sleep?

□ Yes □ No

Do you suffer from either of the following?

□ Dry mouth □ Headache

Do you feel sleepy in the daytime?

□ Yes □ No □ Don't know

How many days per week? _____

When did it start? _____

Is it worsening? □ Yes □ No □ Don't know

How likely are you to doze off or fall asleep

Please use the following scale:

0 Would never doze
1 Slight chance of dozing
2 Moderate chance of dozing
3 High chance of dozing

___ Sitting and reading

___ Watching television

___ Sitting inactive in a public place

___ While a passenger in a car without a break

___ Laying down to rest in the afternoon when circumstances permit

___ Sitting and talking with someone

___ Sitting quietly after lunch without alcohol

___ In a car, while stopped in traffic for a few minutes

Epworth Score: _____

PATIENT **CLINICIAN**

Have you ever had a close call or accident when driving because of sleepiness?
□ Yes □ No □ Don't know

Do you suffer from memory problems?
□ Yes □ No

Are you more irritable lately?
□ Yes □ No

Do you take daytime naps?
□ Yes □ No
How many per week? _____
How long, on average, do they last? _____
Are the naps refreshing?
□ Yes □ No

Rate the severity of your sleepiness on a scale of 1 to 10. (1 being no sleepiness and 10 being severe sleepiness) _____

Do you ever experience restlessness or discomfort in your legs?
□ Yes □ No
When? _____

What relieves the pain? _____

How often does this occur? _____

Does it interfere with sleep?
□ Yes □ No

Do you move or kick your legs while sleeping?
□ Yes □ No

Have you ever felt the sudden loss of strength (arms, legs) in response to some emotional experience?
□ Yes □ No

Have you ever felt paralyzed when you first wake up or when you are falling asleep?
□ Yes □ No

Do you ever dream while you are falling asleep or during naps?
□ Yes □ No

Do you walk or talk in your sleep?
□ Yes □ No

Do you ever accidentally urinate in bed?
□ Yes □ No

Do you have nightmares?
□ Yes □ No

Tell us about your sleep schedule:

What is your bedtime?	Start	End
	═══	═══

How long does it take you to fall asleep? _____

When do you wake up? _____

Do you wake up in the middle of the night?
□ Yes □ No
How many times per night? _____
Do you fall asleep again easily?
□ Yes □ No

Tell us about your daytime schedule.

Work hours (if applicable) _____

If you don't work, how do you occupy your days?

_____

_____

What do you do in the evening?

_____

_____

Patient

Past Family Social History

Are you being treated now or have been treated for any illnesses?

Past Med Hx

1. _____
2. _____
3. _____
4. _____

Have you ever had any operations? Any injuries?

Past Surg Hx

1. _____
2. _____
3. _____
4. _____

Check if any close family member (parents, brothers and sisters, children) have:

Family Hx

- □ Heart problems
- □ High blood pressure
- □ Diabetes
- □ Cancer
- □ Heartburn

Are there any other health problems in your family?

_____

Patient

Clinician: Review of Symptoms

Social Hx

Marital Status S M W D

With whom do you live? _____

What is your occupation? _____

What are your leisure activities? _____

What is your education level? _____

Please circle any symptom that you have, so we can find out more about it:

Urinary

Urinary problems: Frequency; infections; stones; bladder problems

Men: Prostate problems; night-time urination

Women: Abnormal menstrual periods; could you be pregnant?

Musculoskeletal

Joint pains, swelling or redness; arthritis; back pain

Muscle aches or tenderness; gout

Dermatological

Rash, itching or other skin problems

Female Reproductive

Women: breast lumps; recent mammogram, pap smear and/or pelvic exam

Neurological

Paralysis (even temporary); stroke; numbness; loss of balance

Seizures; loss of memory; headaches

Psychiatric

Unusual thoughts; nervousness; crying or sadness; depression

Suicide attempts

Endocrinology

Thyroid disorder; diabetes; excess thirst; hunger or urination

Hematological

Bleeding; easy bruising; risk factors for HIV; anemia; cancer