Sleep and Medical History

Name: ____ Age: __________Date: _______________

Cell Phone Number:______________________ Email Address:___________________________________

Height ______________ Weight ______________ Neck Size ______________ Dress Size ____________

Primary Care Physician _________________________ Referring Physician_________________________

Have you ever had a sleep study before? __________ If yes, do you know what the diagnosis or conclusion was? ____

Have you ever used CPAP or BiPAP before? __________ Are you currently using CPAP or BiPAP? __________ If yes, do you know what the pressure setting is? __________ .

Briefly describe your sleep problem:

____

____

____

____

____

____

Sleep Patterns:

	What time do you typically go to bed?	What time do you typically wake up?
Workday		
Weekend/Vacation		

- How long does it take you to fall asleep? __________
- How many times a night do you wake up? __________ To urinate? __________
- Have you been told that you snore? No / Mild / Moderate / Loud
- Have you been told that your breathing stops or pauses when you sleep? [Yes / No]
- Do you wake up gasping or choking? [Yes / No]

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- Do you wake up with a headache? [Yes / No]
- Are you sleepy during the day? [Yes / No]
- Do you fall asleep at inappropriate times, such as at meetings, the movies, riding in a car, etc? [Yes / No]
- Have you ever been involved in a car accident due to falling asleep behind the wheel? [Yes / No]
- Do you take naps during the day? [Yes / No]
    - How many? _______ How long do they last? _______

- Do you have a restless, uncomfortable or creeping feeling in your legs that is alleviated by walking or moving? [Yes / No]
- Do your legs or arms kick or "jerk" throughout the night? [Yes / No]

- Do you have very vivid dreams, "awake dreams", or feel like you hallucinate when trying to sleep or just when you wake in the morning? [Yes / No]
- Do you ever feel like you cannot move or are temporarily paralyzed soon after lying down to sleep or just after awakening? [Yes / No]
- Do you ever feel a sudden temporary weakness in your knees, neck, voice or arms when laughing, sad, angry, or emotional? [Yes / No]
- Does your speech become slurred or mumbled when you are tired? [Yes / No]
- Does your jaw suddenly go slack when telling a joke or talking so that your speech becomes slurred or mumbled? [Yes / No]

- Do you ever find yourself somewhere and do not know how you got there? [Yes / No]
- Did you ever sleepwalk? [Yes / No]
- Do you talk in your sleep? [Yes / No]
- Do you ever wake up screaming? [Yes / No]
- Have you ever injured (or been concerned that you might injure) either yourself or a bed partner due thrashing about or other violent movements in your sleep? [Yes / No]
- Is the content of your dreams upsetting or frightening for you? [Yes / No]
- Do you ever grind you teeth at night? [Yes / No]

- Has your weight changed recently? [Yes / No]
    - Gained _______lbs. Lost _______lbs.
    - When/Over what period of time? ___________

- Do you ever use sleeping pills? [Yes / No] If yes, how many days of the month do you typically use them? _______ . Please list all sleeping pills and doses (if you know them) of all sleeping pills that you have used:

___

___

___

- Estimate, for an average day, your daily consumption of:
    - Coffee _______ Tea _______ Soda with caffeine _______

- Have you ever smoked cigarettes? [Yes / No]
    - Age when you started smoking? ______
    - Age when you quit smoking? ______
    - How many packs per day? ______
    - When was your last cigarette? ______

Epworth Sleepiness Scale

How likely are you to **DOZE** or **FALL ASLEEP** in the following situations, in contrast to feeling just tired? This refers to your usual way of life in **RECENT TIMES**. Even if you have not done some of these things recently, try to work out how they would have affected to.

Use the following scale to choose the most appropriate number for each situation:

0	=	would **never** doze
1	=	**slight** chance of dozing
2	=	**moderate** chance of dozing
3	=	**high** chance of dozing

Situation

Sitting and reading.	____________
Watching TV.	____________
Sitting, inactive in a public place.(For example, 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	____________

Medical History

1. Please indicate for which of the following **medical** conditions you are currently (*or have ever*) receiving treatment:

- Heart disease (heart attack, murmurs, arrhythmia, congestive heart failure, other) [Yes *please circle and dates* / No] ________
- High blood pressure [Yes / No]
- Diabetes mellitus [Yes / No]
- Elevated cholesterol [Yes / No]
- Seizure or other neurologic condition [Yes / No]
- Stroke [Yes / No]
- History of head trauma [Yes / No]
- Asthma [Yes / No] Age when diagnosed ________
- Emphysema/COPD [Yes / No] Age when diagnosed ________
- Depression [Yes / No]

2. Use the space below to list additional items from your medical history:

____

____

____

____

____

____

____

3. List all your previous surgeries or operations. Make sure you list any prior surgeries or procedures for snoring or sleep apnea. (□ None):

Operation	Year

4. What medicines are you presently taking (□ None)?

Medication	Dose	Frequency

5. List **allergies** or **reactions** to any medications (□ None):

Medication	Reaction

6. Please provide us with your family's sleep medical history. Are you aware of any close relatives with sleeping problems?

7. What is your occupation? Do you do shift/night work?

____

____

____

8. What is your marital status? Do you have any children?

____

____

____

9. How much alcohol do you drink per week? Have you every drunk significantly more than this? Have you ever been treated for alcoholism?

____

____

____

10. Have you used any recreational drugs (including marijuana)? Which and when?

____

____

____

11. Please use the space below to add any additional information from your sleep medical history that you feel is pertinent:

____

____

____

____

____

____

____

______________________________________ ____________________

Patient (or Parent/Legal Guardian Signature) Date