

**SLEEP HISTORY**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

If you were referred to our office by a physician, please list the name: Dr. \_\_\_\_\_

If not, how did you learn about our office? Yellow Pages Internet Friend Other \_\_\_\_\_

**What is your main sleep problem?** \_\_\_\_\_

**How long have you had this problem?** \_\_\_\_\_

**Please list any previously diagnosed sleep disorders** \_\_\_\_\_

Check any of the following that apply:

- Loud snoring
- Breathing or snoring stops for brief periods in my sleep
- Awaken gasping for breath
- Do not feel restored when I awaken
- Difficulty falling asleep
- Difficulty remaining asleep
- Awaken too early
- Become sleepy during the day  
 (please circle any/all that apply)
- sitting       talking
- riding         eating
- driving        standing
- I have had an automobile accident as the driver.

**Sleep Environment**

My bedroom is (loud/quiet) and (light/dark).

My mattress is (soft/hard/just right)?

Do you go to sleep with the television on? Yes \_\_\_\_\_ No \_\_\_\_\_

Is your sleep disturbed because of your bed partner or others in your household (children or pets)? Yes \_\_\_ No \_\_\_\_\_

**Occupation**

What do you usually do at work? \_\_\_\_\_

How does your sleep problem affect your work? \_\_\_\_\_

	Now	1 yr ago	5 yr ago
Weight			
Collar			

**Epworth Sleepiness Scale**

How likely are you to doze off 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 you. 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 (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 with someone \_\_\_\_\_

Sitting quietly after a lunch without alcohol ..... \_\_\_\_\_

In a car, while stopped for a few minutes in traffic ..... \_\_\_\_\_

**Total** \_\_\_\_\_

Indicate ON AVERAGE how often you experience the following symptoms:

Please be as accurate as possible. Indicate AM and PM. If your work and/or sleep schedule changes during the week then indicate your schedule using the “shift work” column

<b>Times weekly</b>	<b>Symptom</b>
	My mind races with many thoughts when I try to fall asleep
	I often worry whether or not I will be able to fall asleep
	Fatigue
	Anxiety
	Memory impairment
	Inability to concentrate
	Irritability
	Depression
	Awaken with a dry mouth
	Morning headaches
	Pain which delays or prevents my sleep
	Pain which awakens me from sleep
	Vivid or lifelike visions (people in room, etc) as you fall asleep or wake up
	Inability to move as you are trying to go to sleep or wake up
	Sudden weakness or feel your body go limp when you are angry or excited
	Irresistible urge to move legs or arms
	Creeping or crawling sensation in your legs before falling asleep
	Legs or arms jerking during sleep
	Sleep talking
	Sleep walking
	Nightmares
	Fall out of bed
	Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep
	Bed wetting
	Frequent urination disrupting sleep
	Teeth grinding
	Wheezing or cough disrupting sleep
	Sinus trouble, nasal congestion or post-nasal drip interfering with sleep
	Shortness of breath disrupting sleep

<b>Activity</b>	<b>Usual schedule</b>	<b>Week ends</b>	<b>Shift Work</b>
Lay down in bed			
Lights out			
I usually fall asleep in (minutes, hours)			
How many times do you awaken each night?			
Number of times you have difficulty returning to sleep			
The total time I spend awake in bed			
Final wake up from sleep			
What time do you usually get out of bed from sleep?			
How many hours of sleep do you get on average?			
If you take naps, how long?			
Begin work time			
End work time			

**MEDICAL HISTORY & ROS:**

Please check if you have had any of the following:

- High blood pressure                       Diabetes                       Anemia
- Skin condition                               Asthma/Emphysema       Acid Reflux       Thyroid condition
- Fibromyalgia                                 Anxiety                       Seizures       Vision problems
- Stroke                                         Depression                       Head Injury or brain surgery
- Parkinson's disease                       Other psychiatric disorder: \_\_\_\_\_
- Heart disease: CHF, heart failure, MI, heart attack \_\_\_\_\_
- Other medical problems (please list): \_\_\_\_\_

Prior Surgeries (please list): \_\_\_\_\_

**MEDICATION**

Do you take anything to help you sleep? \_\_\_\_ Yes \_\_\_\_ No  
If yes, what? \_\_\_\_\_ How often? \_\_\_\_\_

List current medications and dosages, including both prescriptions and over-the-counter medications: \_\_\_\_\_

If you are on oxygen, how much? \_\_\_\_\_ liter/min. How many hours/day? \_\_\_\_\_  
**Drug Allergies (Please list):** \_\_\_\_\_

**SOCIAL HISTORY**

Do you smoke? \_\_\_\_ Did you previously smoke? \_\_\_\_ Do you dip or chew? \_\_\_\_  
How many years of smoking? \_\_\_\_ How much per day? \_\_\_\_\_  
Do you drink alcohol? \_\_\_\_ How much? \_\_\_\_\_ drinks per (day/week/month)  
How much caffeinated coffee, tea or cola do you drink daily? \_\_\_\_\_

**FAMILY HISTORY** (Please check all that apply)

Is there a family history of:	Sleep Apnea	Heavy Snoring	Narcolepsy	Insomnia	Restless Legs Syndrome	Other sleep disturbances
Mother						
Father						
Sister(s)						
Brother(s)						
Grandparent(s)						