

**General:**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

Referring Physician \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Occupation \_\_\_\_\_

**Chief Complaint:**

What are your major complaints related to sleep and wakefulness? (use reverse side if necessary)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you had the above sleep problem? \_\_\_\_\_

Have you ever had a sleep study or been treated for a sleep disorder? \_\_\_\_\_

If so, when? \_\_\_\_\_

What was the diagnosis? \_\_\_\_\_

**Sleepiness:**

Do you take naps during the day?  Yes  No If yes, how long? \_\_\_\_\_

How likely are you to doze off or fall asleep in the following situation, in contrast to feeling just tired?

*Using the scale below please circle the most appropriate number for each situation.*

Epworth Sleepiness Scale

0 - No chance of dozing

1 - Slight chance of dozing

2 - Moderate chance of dozing

3 - High chance of dozing

0 1 2 3 Sitting and reading

0 1 2 3 Watching TV

0 1 2 3 Sitting inactive in a public place (i.e. Theater or Meeting)

0 1 2 3 As a passenger in a car for an hour without a break

0 1 2 3 Lying down to rest in the afternoon when circumstances permit

0 1 2 3 Sitting and talking to someone

0 1 2 3 Sitting quietly after lunch without alcohol

0 1 2 3 In a car while stopped for a few minutes in traffic

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

**Sleep Habits:**

1. What time do you usually go to bed? \_\_\_\_\_
2. What time do you usually wake up in the morning? \_\_\_\_\_
3. How long does it take you to fall asleep? \_\_\_\_\_
4. How many times do you awaken at night? \_\_\_\_\_ What awakens you? \_\_\_\_\_
5. Do you have trouble returning to sleep? \_\_\_\_\_
6. How do you wake up in the morning? (i.e. alarm clock) \_\_\_\_\_
7. What time do you get up in the morning? \_\_\_\_\_
8. Do you usually sleep longer when you don't have to get up? \_\_\_\_\_ How long? \_\_\_\_\_
9. Upon awakening in the morning, do you feel:  
*Completely rested?* \_\_\_\_\_ *Partially rested?* \_\_\_\_\_ *Not rested at all?* \_\_\_\_\_
10. Do you take anything to help you sleep? \_\_\_\_\_

**Symptoms During Sleep** - *Please circle any of the following that apply to you during sleep*

- |                              |                                 |                           |
|------------------------------|---------------------------------|---------------------------|
| <i>Toss and Turn</i>         | <i>Sleep Walking</i>            | <i>Stop Breathing</i>     |
| <i>Teeth Grinding</i>        | <i>Waking Self with Snoring</i> | <i>Nightmares</i>         |
| <i>Snoring</i>               | <i>Loud Snoring</i>             | <i>Night Sweats</i>       |
| <i>Bedwetting</i>            | <i>Heartburn</i>                | <i>Gasping for Air</i>    |
| <i>Urge to Move Legs</i>     | <i>Sleep Talking</i>            | <i>Headache in A.M.</i>   |
| <i>Struggling to Breathe</i> | <i>Choking</i>                  | <i>Frequent Urination</i> |
| <i>Leg Jerks</i>             | <i>Pain</i>                     | <i>Other</i> _____        |

**Medical History:**

List any chronic medical problems

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Any Surgeries or Major Injuries

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Any Drug Allergies \_\_\_\_\_

List any drugs that you take regularly. Please include over the counter medications, hormones, birth control, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

---

**Social and Family History:**

Do you or have you ever smoked?  Yes  No How long? \_\_\_\_\_ How many packs per day? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, how much do you drink? \_\_\_\_\_

How much coffee, tea, or soda do you drink per day? \_\_\_\_\_

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

What are your working hours? \_\_\_\_\_

Does any family member (parent, brother, sister, child, etc.) have a sleeping problem or snore loudly? \_\_\_\_\_

---

**Review of Systems:**

1. Have you had any recent change in your weight? \_\_\_\_\_ How many pounds? \_\_\_\_\_

2. Have you had fever, chills or night sweats?  Yes  No

3. Have you had any recent change in your skin, hair, or voice?  Yes  No

4. Are you urinating more frequently than normal?  Yes  No

5. Have you had any skin rashes or itching?  Yes  No

6. Have you had any recent change in your eyesight or hearing?  Yes  No

7. Have you had any chest pain?  Yes  No

8. Have you had any heart palpitations or pounding?  Yes  No

9. Do you wake up at night short of breath?  Yes  No

10. Do you sleep with more than one pillow under your head?  Yes  No

11. Have you had pain or swelling in your arms, legs, or joints?  Yes  No

12. Do you have heartburn, indigestion, or reflux?  Yes  No

13. Are you having headaches?  Yes  No

14. Do you have symptoms of depression?  Yes  No

15. As you fall asleep or wake up, do you have vivid or lifelike visions?  Yes  No

16. When you are angry or excited, do you have sudden weakness or have any part of your body go limp?  Yes  No

17. As you are trying to go to sleep or wake up, do you ever have an inability to move?  Yes  No

18. Have you ever driven or traveled somewhere and did not remember how you got there?  Yes  No