MD Neurology
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 check 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? ☐ Y ☐ N

Is your sleep disturbed because of your bed partner or others in your household (children or pets)?

☐ Y ☐ N

Occupation

What do you usually do at work? _____

_____

How does your sleep problem affect your work? _____

_____

	Now	1 yr ago	5 yrs ago
Weight			
Collar			

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 _____

Name: _____ **Date:** _____

Indicate **ON AVERAGE** how often you experience the following symptoms:

Times Weekly	Symptoms
☐	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

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

Activity	Usual Schedule	Weekends	Shift Work
Lay down in bed	☐ am ☐ pm	☐ am ☐ pm	☐ am ☐ pm
Lights out	☐ am ☐ pm	☐ am ☐ pm	☐ am ☐ pm
I usually fall asleep In (minutes/ hours)	m / h	m / h	m / h
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	☐ am ☐ pm	☐ am ☐ pm	☐ am ☐ pm
What time do you usually get out of bed from sleep?	☐ am ☐ pm	☐ am ☐ pm	☐ am ☐ pm
How many hours of sleep do you get on average?			
If you take naps, how long?			
Begin work time	☐ am ☐ pm	☐ am ☐ pm	☐ am ☐ pm
End work time	☐ am ☐ pm	☐ am ☐ pm	☐ am ☐ pm

Name:_____ **Date:**_____

MEDICAL HISTORY

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 ☐ 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? ☐ Yes ☐ No Did you previously smoke? ☐ Yes ☐ No
Do you dip or chew? ☐ Yes ☐ No
How many years of smoking? _____ How much per day?_____
Do you drink alcohol? ☐ Yes ☐ No 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)	☐	☐	☐	☐	☐	☐