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 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 _____

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

Times Weekly	**Symptom**
	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

Name_____**Date**_____

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			
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			

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 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)						