Patient Sleep Medical History

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male Female DOB: \_\_\_\_\_\_\_\_

Have you ever been diagnosed with sleep apnea? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever worn, or do you wear a CPAP or BIPAP device? ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you snore? Yes/No All night Periodically In one position

If positional what position\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Intensity of snoring Mild Moderate Severe

Do you awaken gasping or choking? Yes No

Do you awaken short of breath? Yes No

Do you have apneas (pauses in breathing)? Yes No

Who has observed the apneas? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do they awaken you? Yes No

Does your bed partner elbow you during sleep because you snore or have pauses in

your breathing Yes No

How long are the apneas? \_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel sleepy during the day? Yes No

Does sleepiness affect your work performance? Yes No Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_

Have you fallen asleep at work? Yes No

Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How likely are you to “doze off” or fall asleep in the situations described below?

Using the following scale, select the number that is most appropriate for you and write in the space after each situation.

0 – I would never doze off.

1 – There is a slight chance I would doze.

2 – There is a moderate chance I would doze.

3 – There is a high chance I would doze.

Sitting and Reading \_\_\_\_\_\_\_\_\_\_

Watching television \_\_\_\_\_\_\_\_\_\_

Sitting inactive in public place meeting or classroom \_\_\_\_\_\_\_\_\_\_

As a passenger in a car for 1 hour \_\_\_\_\_\_\_\_\_\_

Lying down to rest in the afternoon \_\_\_\_\_\_\_\_\_\_

Sitting and speaking to someone \_\_\_\_\_\_\_\_\_\_

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

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

Do you take naps during the day? Yes No Do you feel better? Yes No

Have you ever had a motor vehicle accident due to sleepiness? Yes No

Do you ever get sleepy while driving? Yes No

 If yes, what do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a commercial driver’s license? Yes No

Do you drink alcohol prior to bedtime? Yes No How much? \_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_

Do you eat before bedtime? Yes No How much? \_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_

Do you drink caffeinated beverages? Yes No How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which: Coffee Tea Soda Pop Energy drinks When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What time do you go bed? Weekdays \_\_\_\_\_\_\_\_\_\_\_ Weekends\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long does it take for you to fall asleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What time do you get up in the morning? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you awaken during the night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you awaken and urinate? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours of sleep do you usually get a night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel rested when you wake up in the morning? Yes No Sometimes

Do you sleep with a bed partner? Yes No

Do you talk in your sleep? Yes No

Do you sleepwalk? Yes No Have you had any injuries? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have: High blood pressure Heartburn Night sweats Nasal congestion

 Irregular heartbeat on awakening Morning headaches Dry mouth

  Broken your nose Poor concentration Swelling in ankles/feet

 History of Stroke History of Heart Attack History of Heart Failure (CHF)

Do you have chronic pain that keeps you from sleeping? Yes No

If yes explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use street drugs? Yes No Explain if yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you toss and turn at night? Yes No Do you have restless sleep? Yes No

Do you kick your feet during the night while asleep? Yes No

Have you used any sleeping pills? Yes No

 Which ones have you tried? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your weight been stable? Yes No

 If not, how has it changed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you grind your teeth at night? Yes No

Do you have restless legs (crawling, achy or inability to keep legs still)? Yes No

Is it better with getting up and moving? Yes No Is it worse with relaxation? Yes No

Is it worse during the course of the: Day Early evening Night

Does it make it difficult to fall asleep? Yes No