Place patient ID label here

SLEEP HISTORY AND CURRENT SLEEP HABITS		
During your sleep , do you currently have or in the last 6 months have had any of the following problems? (Please check all that apply)		
○ Excessive daytime sleepiness	○ Restless Sleeper	○ Muscle weakness or falls when laughing or scared.
○ Loud Snoring	○ Nightmares/Night terrors	○ Morning fatique
○ Stop breathing in your sleep	○ Sleep walking/talking	○ Morning headaches
○ Dry mouth at night	○ Wake up and cannot move (paralyzed) for several minutes	○ Palpitations at awakening
○ Gasping/Choking sensation	○ Frequent trips to bathroom	○ Shortness of breath when lying down
○ Difficulty initiating/maintaining sleep	○ Drooling at night	○ Heartburn/gas pains
○ Frequent arousals from sleep	○ Leg discomfort before falling asleep	○ Night sweats
○ Sudden kicking or jerking movements as you fall asleep	○ Leg cramps while sleep	○ Cold extremities

Please circle the response that apply to the question below:

What is your usual bed time?		What is your usual rise time?	
Have you ever hurt yourself during sleep?			Yes No
Have your movements during sleep ever hurt others?			Yes No
Do you experience discomfort in your legs in the evening while relaxing that is relieved by moving them?			Yes No
Do you experience leg cramps at night that wake you and is relieved by moving them or walking?			Yes No
Have you ever had a sleep study?			Yes No
If yes, where and when:			
Do you sleep alone?			Yes No
If no who sleeps in bed with you:	Spouse Significant Other Child Parent Pet		
How would you describe your sleep?	Excellent Good Fair Poor Very Poor		
How would you describe your bed partners sleeping?	Excellent Good Fair Poor Very Poor		
How regular are your sleep habits?	Very Regular Usually Regular Usually Irregular Very Irregular		
How long does it usually take you to fall asleep?	0-10 min 11-20 min 21-30 min 31-60 min more than 60 min		
How many times do you wake up during an average night?	0 1 2 3 4 5 more than 5		
When you wake up during the night, how long does it usually take you to fall back to sleep?			
If you can't fall back to sleep do you get out of bed?	Yes No		
Do you watch television or listen to music to help you fall back asleep?	Yes No		
How many hours of sleep do you get each night on the average?	<5hrs 6 hrs 7 hrs 8 hrs 9 hrs > 9 hrs		
Do you keep the same schedule on weekends or days off of work?			
How often is your sleep disrupted by discomfort or pain?	0 1 2 3 4 5 more than 5		

Please describe your normal work hours?	
If you do shift work, how often does your shift change?	

Place patient ID label here

HEALTH HABITS AND PERSONAL SAFETY

Exercise	○ Sedentary (No exercise)
	○ Mild exercise(i.e., climb stairs, walk 3 blocks, golf)
	○ Occasional vigorous exercise (i.e. work or recreation, less than 4x/week for 30 min)
	○ Regular vigorous exercise (i.e. work or recreation , more than 4x/week for 30 min)

Diet	○ Are you dieting? Yes or No
	○ If yes are you on a physician prescribed medical diet? Yes or No
	○ # of meals you get in an average day?

Caffeine	None	Coffee	Tea	Cola
	Amount/day	Cups/day	Cups/day	Cans/day

Alcohol	Do you drink alcohol? Yes or No
	If yes what kind?
	How many drinks per week? 1-2 3-4 5-6 7-8 more than 8

Tobacco	Do you use tobacco?
	Cigarettes- Packs a day? Chew - #per day? Pipe- # per day? Cigars - # per day?
	# of years ? Or year quit? Do you smoke within 4 hours of bedtime? Yes or No

DAYTIME FUNCTIONING	
Do you feel FATIGUE (tiredness, exhaustion, lethargy) in the daytime even when you are not sleepy?	No Infrequently Occasionally Often Always
Do you feel SLEEPY (struggle to stay awake) in the daytime?	No Infrequently Occasionally Often Always
If so under what circumstances do you fall asleep easily? (circle all that apply)	Driving After Meals Meetings/Class/Church Reading/Watching TV Other
Does your daytime sleepiness interfere with: (Please circle all that apply)	Household chores Relationships Job Performance School
Have you ever had an accident or near miss from falling asleep while driving?	Yes or No
How often do you feel alert and energetic for an entire day?	Never Sometimes Most of the time All the time
Do you take naps (intentional or unintentional) during the day?	Yes or No
If so how often and for how long?	
Do you feel refreshed after naps?	Yes or No
Primary Care Physician:	Last Physical exam:

Place patient ID label here

ACUTE SLEEP SYMPTOMS	
In your own words, please describe your main sleep problem:	
How long has this been a problem?	Last 3 months Last 6 months Last year more than 1 year
Is this problem:	Getting worse getting better staying the same

CLINICAL DATA QUESTIONS	
Are you currently taking any blood pressure medication? If "YES" how many? 1 2 3 4	Yes or No
Are you currently taking a sleeping pill (prescription or over the counter)?	Yes or No
If yes, what and when:	
Are you on any pain medications?	Yes or No

Have you ever been diagnosed with the following? (Please circle)

Coronary Artery Disease	Atrial Fibrillation	Pacemaker	Stroke
Congestive Heart Failure	Diabetes	Internal Defibrillator	TIA- (mini stroke)

PERSONAL HEALTH HISTORY

Allergies: (Please list any food, medication or environmental allergies AND the reaction you had:

Physical Information: Height: Weight: Neck Size:

How would you currently describe your health: Excellent Good Fair Poor Very Poor

MOOD AND COGNITION	
Has your memory been getting worse lately?	Yes or No
Have you had difficulty concentrating lately?	Yes or No
Have you been feeling more irritable lately?	Yes or No
Have you ever been treated for anxiety, depression or severe stress?	Yes or No
Have you been feeling more depressed lately?	Yes or No
How much stress would you say you are under right now?	More than usual Less than usual The same
Is your stress related to: (Please circle all that applys)	Work Personal Other
Have you felt:	Hopeless Helpless Worthless Useless
How is your appetite?	Worse than usual Better than usual The same
In response to intense emotion (laughter, anger, surprise) have you felt sudden muscle weakness in your legs, neck or other extremities?	Yes or No
Before you fully fall asleep, do you have vivid, sometimes frightening dreams like hallucinations?	Yes or No

Signature of Person Completing Form:____ Date:_________________

Place patient ID label here

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	○ If yes are you on a physician prescribed medical diet? Yes or No
	○ # of meals you get in an average day?

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	Amount/day	Cups/day	Cups/day	Cans/day

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	Do you drink alcohol? Yes or No
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	How many drinks per week? 1-2 3-4 5-6 7-8 more than 8

Tobacco	
	Do you use tobacco?
	Cigarettes- Packs a day? Chew - #per day? Pipe- # per day? Cigars - # per day?
	# of years ? Or year quit? Do you smoke within 4 hours of bedtime? Yes or No

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If so how often and for how long?	
Do you feel refreshed after naps?	Yes or No
Name (Last, First, M.I.):	DOB:

Place patient ID label here

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Signature of Person Completing Form:____ Date:________________

Tech's Signature:____ Date: ________________