

MEDICAL HISTORY

Have you ever been told by a doctor that you have:

YES

- Hypertension (high blood pressure)
- Thyroid gland problems
- Heart Disease
- Angina
- Stroke
- Cancer
- Kidney disease

YES

- Asthma
- Emphysema or chronic bronchitis
- Depression or other psychiatric disorders
- Sinusitis
- Liver disease
- Diabetes
- Gastro-esophageal reflux

Do you have other medical problems? If so, please list them here: _____

Surgical History/Hospitalizations:

- Tonsillectomy (tonsils taken out)
- History of trauma
- Other surgeries/hospitalizations _____

Your Height: _____ **Weight:** _____

Has your weight changed? **Yes** or **No** If yes, How much? _____ How long ago? _____

MEDICATIONS:

List the medications that you currently take (including the ones you can get without a prescription):

Write "none" if you do not take any.

<u>NAME</u>	<u>DOSE</u>	<u>NAME</u>	<u>DOSE</u>
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Do you ever use sleeping pills, tranquilizers or sedatives? **Yes** / **No**

If yes, please list: _____

MEDICATION ALLERGIES: _____ **NONE** _____ **Iodine** _____ **Latex** _____ **Medical Tape**

(List Allergies Below)

METHOD OF LEARNING WHICH WORKS BEST FOR YOU?

_____ Reading _____ Watching a video _____ Observing someone

SOCIAL HISTORY:

Married _____ Single _____ Widow _____ Divorced _____

of children _____ If you have children, do they live with you? Yes / No

Do you smoke cigarettes, cigars or a pipe?

Yes—packs/day _____ years _____
Quit—packs/day _____ # years smoked _____ quit _____
Never smoked _____

How much of the following do you use:

	Per weekday	Per weekend day
Coffee	_____	_____
Tea	_____	_____
Chocolate	_____	_____
Caffeinated soda	_____	_____
Alcohol	_____	_____
Recreational drugs	_____	_____

SLEEP HABITS

	<u>Weekdays</u>	<u>Weekends</u>
What time do you go to bed?	_____ am/pm	_____ am/pm
What time do you get up?	_____ am/pm	_____ am/pm
How long does it take you to fall asleep?	_____ min/hrs	_____ min/hrs
On average, how many hours of actual sleep do you get nightly?	_____ hours	_____ hours
On average, how many times do you wake up during the night?	_____ times	_____ times
Do you return to bed after arising?	Yes / No	Yes / No
What time do you go to work or school?	_____ am/pm	_____ am/pm
What time do you return home?	_____ am/pm	_____ am/pm

Does your job require working different shifts? **Yes / No** If yes, which shifts? _____

Do you take naps? **Yes / No**. If yes, how often during the day? _____, the evening? _____

What do you do at night when you wake up? _____

Do you worry about your sleep problem during the daytime? **Yes / No**

How do you sleep away from home (e.g. on a vacation)? _____

Do you watch T.V., read, eat, etc. in bed? **Yes / No**

Do you fall asleep more easily on the couch than in bed? **Yes / No**

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	Chance of Dozing
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 quietly after a lunch without alcohol?.....	_____
Sitting and talking to someone?	_____
In a car, while stopped for a few minutes in traffic?.....	_____
	Total _____

SLEEP SYMPTOMS

1. Do you snore?..... yes / no
2. Does your snoring prevent somebody from sleeping in the same bed with you?.....yes / no
3. Do you wake up gasping or feeling you can't breathe?..... yes / no
4. Has your bed partner ever told you that you stop breathing during sleep?..... yes / no
5. Do you wake up with a headache?..... yes / no
6. Do you have a restless or creepy feeling in your legs that is decreased by moving your legs or walking or prevents you from sleeping?..... yes / no
7. Has your bed partner ever noticed leg movements while you were sleeping?..... yes / no
8. Does your bed partner complain that you kick them during the night?..... yes / no
9. If so, does it prevent him or her from sleeping in the same bed with you?..... yes / no

10. Do you toss and turn?..... yes / no
11. Do you wake up feeling tired, disoriented, foggy?..... yes / no
12. Have you ever had an automobile accident related to sleepiness?..... yes / no
13. Have you ever had accidents at work related to sleepiness?..... yes / no
14. Do you ever find yourself somewhere and do not know how you got there?..... yes / no
15. Do you have vivid dreams shortly after falling asleep at night?..... yes / no
16. Do you ever feel that you cannot move after lying down or just after you wake?..... yes / no
17. Do you ever feel sudden weakness in your limbs when laughing?..... yes / no
18. When you wake up, are you short of breath or wheezing?..... yes / no
19. Do you grind your teeth at night?..... yes / no
20. Do you wake up during the night for no apparent reason?..... yes / no
If yes, do you have trouble going back to sleep..... yes / no
21. Do you wake up during the night and have trouble going back to sleep?..... yes / no
22. Do you wake up early in the morning and cannot go back to sleep?..... yes / no
23. Do you wake up at nights with thoughts racing through your mind?..... yes / no
24. Do you get up more than once a night to urinate?..... yes / no
25. Do you have difficulty falling asleep or wake up frequently throughout
the night because of pain?..... yes / no
26. Are you easily awakened by noise or light?..... yes / no
27. Do you feel frustrated or tense when seeing your bed or bedroom?.....yes / no
28. Have you felt depressed recently?..... yes / no
29. Have you been having marital conflict lately?.....yes / no
30. Do you have job stress?.....yes / no
31. Do you find it difficult to get out of bed in the morning?.....yes / no
32. Is your job or school performance affected by your sleep problem?.....yes / no

FAMILY HISTORY

Has anyone in your family been diagnosed with sleep apnea, narcolepsy, insomnia or other sleep disorders?

Yes _____ No _____ Which family members _____

Do your family members have:		Y	N		Y	N	
	Y	N	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer <input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>		
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>					

Review of systems

Do you presently have?

General:	Y	N	Cardiac:	Y	N	Lungs:	Y	N
Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Change in weight	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>
Loss of energy	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmurs	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Fevers/chills	<input type="checkbox"/>	<input type="checkbox"/>	Heart attacks	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Colds	<input type="checkbox"/>	<input type="checkbox"/>
			Difficulty laying flat	<input type="checkbox"/>	<input type="checkbox"/>			

Pain **N**
If yes, where? _____

Skin:
Rashes **N**
Change in skin color **N**
Unhealed sores **N**

Gastrointestinal	Y	N	Urinary	Y	N	Emotion:	Y	N
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Burning in urine	<input type="checkbox"/>	<input type="checkbox"/>	Crying spells	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Increased urine	<input type="checkbox"/>	<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Trouble in start/stop	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>						
Constipation	<input type="checkbox"/>	<input type="checkbox"/>						

Blood:			Muscles/Skeleton:	Y	N	Eyes/Ears/Mouth:	Y	N
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Vision trouble	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Morning stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>	Back problems	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	<input type="checkbox"/>
			Ankle Edema	<input type="checkbox"/>	<input type="checkbox"/>	Ring in ears	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine:	Y	N	Neurologic:	Y	N	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Hair growth/loss	<input type="checkbox"/>	<input type="checkbox"/>	Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	Dental problems	<input type="checkbox"/>	<input type="checkbox"/>
			Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Increased thirst	<input type="checkbox"/>	<input type="checkbox"/>	Memory changes	<input type="checkbox"/>	<input type="checkbox"/>	Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>
Increased hunger	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Heat/cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Trouble talking	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
			Balance problems	<input type="checkbox"/>	<input type="checkbox"/>			

T: (shared drive)/ Forms/Sleep Questionnaire