



NEW PATIENT HISTORY – PATIENT FORM

It is essential that you arrive to your appointment with this **form filled out** to the best of your ability. Failure to do so may result in delays in your visit. **Please bring in any sleep records** that you may have of previous sleep studies. If you are currently using a CPAP (any type), please bring the SD Card to your appointment if your machine has one.

Personal Information

Name: _____ DOB: _____
Preferred First Name: _____ Email: _____
Phone: Home:(_____) _____ Cell:(_____) _____ Work:(_____) _____

Medications, prescriptions and over the counter (i.e. supplements, birth control, aspirin, and topical) medications:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Sleep Questionnaire

1. Why are you being referred to the Sleep Center? _____

2. Were you referred here by the Department of Transportation or an occupational health physician?
 YES NO
3. Have you ever seen a sleep specialist before?
 YES NO If yes, for what? _____



4. Do you use Oxygen at home? YES, _____ liters per minute during sleep 24/7
 NO

5. Have you ever had a sleep study before? YES NO
If so, what were the results? NORMAL ABNORMAL

Where was it performed and when? _____

6. Have you ever been prescribed a CPAP or related machine? YES NO

If yes, what is/was the pressure set to? _____ What mask do you use? _____

Are you currently using this machine? YES NO

If not, why not? _____

7. What company (DME) provides your CPAP machine, masks, and equipment? _____

8. Are you being considered for bariatric surgery? YES NO

9. Are you currently on, or have you tried sleep medications in the past? If so, please list the medication, dosage (if known), dates of use, and how effective they were for you.

10. Are you currently on, or have you ever been prescribed stimulant medications in the past? (example, Ritalin, Provigil) YES NO

If yes, please list the stimulant(s) prescribed: _____

Why were they prescribed? _____

11. Do you or your bed partner have a pacemaker or defibrillator? YES NO

12. Do you or your bed partner have a metallic hemostatic clip implanted in your head to repair an aneurysm? YES NO

13. Do you or your bed partner have metallic splinters in one or both eyes following a penetrating injury? YES NO

14. Do you have a spinal cord stimulator? YES NO

If yes, can it be turned off? YES NO

FOR FEMALE PATIENTS ONLY:

15. Are you currently pregnant, or do you plan on becoming pregnant in the near future?

YES NO



SLEEP PROBLEM CHECKLIST

The following is a list of symptoms that may be experienced by people with sleep problems. Please check (☑) only the symptoms that you have experienced.

☑ Box

<input type="checkbox"/>	Snoring with sleep
<input type="checkbox"/>	My family complains about my snoring
<input type="checkbox"/>	Waking up with a choking or gasping sensation
<input type="checkbox"/>	Someone has told me I stop breathing when I sleep
<input type="checkbox"/>	Dry mouth or sore throat upon awakening
<input type="checkbox"/>	Headaches upon awakening
<input type="checkbox"/>	Acid reflux or heartburn that disturbs your sleep
<input type="checkbox"/>	Nasal congestion, obstruction or discharge at night

<input type="checkbox"/>	Excessive fatigue or sleepiness
<input type="checkbox"/>	Fall asleep or doze off unintentionally
<input type="checkbox"/>	Sleepiness while driving (i.e. falling asleep at red light, stop sign or drifting onto rumble strips)
<input type="checkbox"/>	Forgetfulness or decreased concentration
<input type="checkbox"/>	Sudden loss of muscle tone triggered by intense emotion (i.e. surprise, laughter or anger)
<input type="checkbox"/>	Temporary inability to move or speak while falling asleep or waking up
<input type="checkbox"/>	Hallucinations when falling asleep or waking up from sleep

<input type="checkbox"/>	Urge to move legs due to uncomfortable or unpleasant feelings in the legs
<input type="checkbox"/>	Creeping, crawling or uncomfortable sensation of legs when sitting or before sleep
<input type="checkbox"/>	Uncomfortable sensation of legs that improves with movement
<input type="checkbox"/>	Kicking or jerking of legs while sleeping

<input type="checkbox"/>	Difficulty sleeping or problems at work due to shift work
<input type="checkbox"/>	Tendency to be a “night owl” or stay up very late
<input type="checkbox"/>	Tendency to be a “morning lark” or go to bed very early

<input type="checkbox"/>	Walking while sleeping
<input type="checkbox"/>	Falling out of bed
<input type="checkbox"/>	Pounding, punching, kicking or acting out dreams during sleep
<input type="checkbox"/>	Loud talking or screaming during sleep
<input type="checkbox"/>	Disturbing dreams
<input type="checkbox"/>	Have you had any traumatic experiences in the bedroom?
<input type="checkbox"/>	Night time panic attacks
<input type="checkbox"/>	Grinding or clenching teeth in your sleep



TYPICAL SLEEP SCHEDULE

Do you take sleep aids? If so, what medication(s) and at what time do you take them? _____ _____	_____ am / pm _____ am / pm
Over the past month, what has been your bedtime routine? (ex. TV, reading, bath,) _____ _____	
Over the past month, what has been your average bedtime (one time)?	_____ am / pm
Over the past month, what has been the average time that you wake to start your day (one time)?	_____ am / pm
How long does it take you to fall asleep at night (estimated)?	_____ minutes
How many hours of sleep do you estimate that you get each night?	_____ hours
How many times do you wake-up during the night?	_____ times
How long do you estimate that you are awake in total during these awakenings?	_____ minutes
How many times do you usually urinate during the night?	_____ times
At the end of your sleep period, you awaken:	_____ spontaneously _____ alarm clock
Do you typically feel refreshed on awakening?	____ Yes ____ No
Do you take naps?	____ Yes ____ No
If you take naps, please indicate how frequently you nap.	___ more than once a day ___ once a day ___ several days a week ___ rarely
What time of day do you usually nap?	_____ am / pm
How long are your naps?	_____ minutes
Any differences on weekends or days off? _____ _____ _____	



Past Medical History: Check all that apply.

<input type="checkbox"/> Heart Attack (Myocardial Infarction) <input type="checkbox"/> Congestive Heart Failure (CHF) <input type="checkbox"/> Heart Disease <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Arrhythmias (Irregular Heart Rhythm) <input type="checkbox"/> Atrial Fibrillation (A-Fib) <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Pacemaker/Defibrillator <input type="checkbox"/> Peripheral Edema (swelling in the feet/legs)	<input type="checkbox"/> Migraine <input type="checkbox"/> Headache <input type="checkbox"/> Seizure / Epilepsy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS) <input type="checkbox"/> Stroke <input type="checkbox"/> Transient Ischemic Attack (TIA) <input type="checkbox"/> Brain Tumor <input type="checkbox"/> Parkinson's Disease Or Parkinsonism <input type="checkbox"/> Elevated Intracranial Hypertension (Pseudo Tumor Cerebri) <input type="checkbox"/> Traumatic Brain Injury (TBI) <input type="checkbox"/> Neuropathy	<input type="checkbox"/> Type 2 (Adult-Onset) Diabetes <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> BPH (Enlarged Prostrate) <input type="checkbox"/> Excessive Night Time Urination <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Gastroesophageal Reflux Disease (GERD) <input type="checkbox"/> Chronic Constipation <input type="checkbox"/> Chronic Diarrhea
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) <input type="checkbox"/> Emphysema <input type="checkbox"/> Asthma <input type="checkbox"/> Allergies	<input type="checkbox"/> Chronic infectious disease Please circle any that apply: (MRSA, TB, VRE, Hepatitis, and HIV) <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Chronic Pain Location / Type: _____ _____	<input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Dementia or Cognitive Impairment <input type="checkbox"/> Memory Problems <input type="checkbox"/> ADD / ADHD <input type="checkbox"/> Post-Traumatic Stress Disorder (PTSD) <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Claustrophobic <input type="checkbox"/> Other Psychiatric Diagnoses _____ _____ _____
<input type="checkbox"/> Elevated Red Blood Cell Counts/Polycythemia <input type="checkbox"/> High Cholesterol Or Triglycerides <input type="checkbox"/> Anemia <input type="checkbox"/> Low Testosterone <input type="checkbox"/> Low Vitamin D	<input type="checkbox"/> Floppy Eyelid Syndrome <input type="checkbox"/> Glaucoma <input type="checkbox"/> Blindness	

PAST SURGICAL HISTORY

Tonsils / Adenoids Removed Uvulopalatopharyngoplasty (UPPP)
 Nasal / Sinus Surgery Bariatric Surgery Deep Brain Stimulation

Any Other Surgeries: _____

Do you use a walker? YES NO
 Do you use a wheelchair? YES NO
 Do you use a cane? YES NO
 Do you sleep in or need a hospital bed? YES NO
 Do you experience incontinence? YES NO
 Do you need a bedside commode or urinal? YES NO
 Do you need a caregiver to stay with you if you have a sleep study? YES NO



Review of Systems

Please indicate if you currently experience any of the following.

General

- Fatigue
- Weight Loss
- Weight Gain
- Jaw Joint Pain – TMJ

Neurological

- Headache
- Insomnia
- Snoring
- Restless Legs

Genitourinary

- Frequent Night time Urination
- Decreased Libido/Sex Drive
- Males: Difficulty Maintaining Erections

Musculoskeletal

- Back Pain
- Joint Pain
- Night Time Muscle Cramps

Psychiatric

- Depression
- Anxiety
- Memory Loss

Cardiovascular

- Chest Pain
- Palpitations
- Leg Swelling

Skin

- Rash

Respiratory

- Cough
- Shortness of Breath
- Wheezing

Ear Nose Throat

- Nasal Congestion
- Nose Bleeds

Gastrointestinal

- Acid Reflux/Heartburn
- Nausea

Social History

- Please check: Married Single Divorced Widowed
- Children: None Yes, living with me No, not living with me

1. Do you have a Commercial Driver’s License? _____
2. Occupation: _____
Place of Work: _____
 Full time Part-time Retired Disabled Unemployed
3. Tobacco Use: NO YES If yes, indicate how much _____
4. Alcohol Use: NO YES If yes, indicate how much _____
5. Caffeinated Beverage Use: NO YES If yes, how much/what time of day _____
6. Drug Use: NO YES If yes, indicate how often _____
7. Exercise: NO YES How often/what time of day _____

Family History

Please indicate illnesses that your first degree family members have but not you. Include their relation to you and approximate age of onset, if known, to the best of your ability.

<i>Medical Condition</i>	<i>Family Member(s) Affected and Age of Onset</i>
Snoring	
Sleep Apnea	
Restless Leg Syndrome (RLS)	
Sleep Walking	
Insomnia	
Narcolepsy	



Epworth Sleepiness Scale (ESS)

How likely are you to doze or fall asleep in the following situations, in contrast to feeling just 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 circle the *most appropriate number* for each situation.

0 = would *never* doze 2 = moderate chance of dozing
 1 = slight chance of dozing 3 = high chance of dozing

Situation	Chance of Dozing			
Sitting and reading.	0	1	2	3
Watching television.	0	1	2	3
Sitting, inactive in a public place (at a theater or meeting).	0	1	2	3
As a passenger in a car for an hour without a break.	0	1	2	3
Lying down to rest in the afternoon when circumstance permits.	0	1	2	3
Sitting and talking to someone.	0	1	2	3
Sitting quietly after lunch without alcohol.	0	1	2	3
In a car, while stopped for a few minutes in traffic.	0	1	2	3
Total (nurse to calculate)				

The Fatigue Severity Scale (FSS)

FSS Questionnaire: Please circle from 1 to 7 to indicate how well each statement describes you.

During the past week, I have found that:	Least like me				Most like me		
1. My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
2. Exercise brings on my fatigue.	1	2	3	4	5	6	7
3. I am easily fatigued.	1	2	3	4	5	6	7
4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
8. Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7

Average (nurse to calculate): _____

Please note any additional information that you feel would be helpful to the physician.

For Office Use:

This document was reviewed and additional comments made where appropriate by physician.

Physician: _____ Date: _____ Time: _____



Do you regularly have a bed partner? NO YES

If yes, please have him/her fill out the information below.

Bed Partner Questionnaire

Patient Name _____ Your Name _____ Date _____ Time _____

I have observed this person's sleep: _____ Never _____ Rarely _____ Often _____ Every Night

Check any of the following behaviors that you have observed this person doing while asleep.

	Light Snoring		Loud Snoring		Moderate Snoring
	Choking		Pauses in breathing How long? _____		Twitching/kicking of legs during sleep
	Grinding teeth		Sleep Walking		Getting out of bed, but not awake
	Bed wetting		Biting Tongue		Actually sleeping even if behaves otherwise
	Crying out		Becoming rigid/shaking		Sitting up in bed, but not awake
	Falling out of bed		Acting out dreams (ex. punching, kicking)		Other _____ _____

Please describe the sleep behaviors checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

Has this person ever fallen asleep during normal daytime activities or in a situation that may become dangerous?

YES NO If yes, please describe: _____

