

University Services

DATE: _____

Referring Physician _____

Primary Care Physician _____

NAME: _____ AGE: _____ DOB: _____

MARITAL STATUS: Single Married Widowed Divorced Separated

SLEEP HISTORY

Briefly describe your sleep problem:

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Review of Systems

FILL IN BLANKS AND CIRCLE CORRECT ANSWER

Workdays

Days Off

Usual bedtime _____ am / pm

_____ am / pm

Arising hour _____ am / pm

_____ am / pm

Time it takes to fall asleep: _____ hour's _____ minutes

Do you have awakenings during sleep? Yes No

If yes: Number per night: _____

Usual Length: _____

Specific Causes: _____

Out of bed with awakenings Yes No

OFFICE USE ONLY

Date of Initial Visit _____

Please Check All that Apply

During the time it takes to fall asleep, do you:

- Have thoughts racing through your mind
- Feel sad, depressed, or worried
- Feel anxious or nervous
- Feel afraid of not being able to fall asleep
- Experience creeping/crawling/aching feelings in legs and/or an inability to keep legs still
- Worry about it the next day if you don't sleep well

Do you:

- Sleep in bed with a partner
- Talk in your sleep
- Walk in your sleep
- Have behaviors during sleep witnessed by others but you yourself do not recall
- Often have frightening dreams
- Consider yourself a restless sleeper
- Consider yourself a light sleeper
- Depend on an alarm or someone to wake you in the morning?

How much time do you spend in bed after waking up in the morning?

During the first 30 minutes after waking up, do you feel?

- Very drowsy
- Moderately drowsy
- Slightly drowsy
- Alert

Since the beginning of your sleep problem, have you slept away from home? Yes No

If yes, was your sleep different? Yes No

If yes, describe: _____

Do you snore? Yes No

If yes:

How many years have you been snoring? _____

- Snore every night
- Snoring disturbs others
- Awakened yourself with your own snoring
- Awakened feeling short of breath or with a choking feeling
- Someone has observed pauses in your breathing while you were sleeping
- Frequently wake up with headaches
- Sleep posture affects your snoring

What is your usual sleeping position? Back Side Abdomen

Are you sleepy during the day? Yes No

If yes:

How long ago did daytime sleepiness begin? _____

Do you:

- Get so sleepy during the day that it affects your work
- Doze off during the day
- Get sleepy while inactive such as watching TV, reading, etc.
- Fall asleep at inappropriate times such as while driving, eating, or during a conversation
- Feel tired and exhausted during the day
- Take rests without sleeping

Do you take naps? Yes No

If yes:

Are your naps: Planned Spontaneous Both

- Naps are refreshing
- Naps are followed by grogginess
- Dream during your naps

Do you have memory problems? Yes No

Have you:

- Experienced **sudden** weakness in your legs or other body parts particularly while in an emotional situation
- Felt paralyzed or unable to move while waking up or falling asleep
- Had hallucinations or dream-like images while not actually asleep, but while falling asleep or waking up

Medical History and Review of Systems

Significant illnesses/injuries as a child _____

Past Medical History

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Coronary Artery Dx | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Headache | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Gout | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Panic Disorder | <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Reflux | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease | |
| <input type="checkbox"/> Other _____ | | | |

- Women Only:** Premenopausal Perimenopausal Postmenopausal
- Irregular Menses (describe) _____
- Infertility

Surgeries:

- | | | | |
|---------------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Bariatric | <input type="checkbox"/> C-Section | <input type="checkbox"/> Coronary Artery Bypass |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Nasal Polyps | <input type="checkbox"/> Nasal Septum |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Sinus | <input type="checkbox"/> Tonsillectomy | |
| <input type="checkbox"/> Other _____ | | | |

Current Weight _____ lbs

Weight 1 year ago _____ lbs

Weight 5 years ago _____ lbs

Height ____ ft ____ in

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BMI	_____

Allergies

Penicillin Sulfa Aspirin Codeine / Morphine

Other _____

No Known Drug Allergies

Medications

Do you use oxygen at home? Yes No

Social History

Smoke cigarettes Packs per day _____ For how many years? _____

Smoke cigars / pipe Number per day _____ For how many years? _____

Smoked cigarettes/cigars/pipes in the past
Amount smoked and number of years: _____

Do you drink?

Alcohol: Beer Wine Liquor
How much? _____

Coffee How much? _____

Tea / Iced Tea How much? _____

Colas How much? _____

Any recent change in your intake of cigarettes, alcohol, or caffeine? Yes No

If yes, describe _____

Do you use Recreational Drugs? Yes No

Which ones? Amphetamines Benzodiazepines Cocaine

Marijuana Opiates PCP

Other _____

Family History

	Age	Health	Medical / Sleep Problems
Mother	_____	_____	_____
Father	_____	_____	_____
Sister	_____	_____	_____
Brother	_____	_____	_____

History of sleep disorders in other family members including siblings

Describe: _____

Personal History

Present Occupation _____

If none:

Retired Disabled Homemaker Other _____

Fired or quit work because of a sleep disorder or other medical problem Yes No

Describe: _____

Who is living with you now? (Spouse, children, in-laws, etc.)

Children:

Name	Age	Living with You	Healthy
_____	_____	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

The above information is true and correct to the best of my belief.

Signature _____

Date _____