Patient Sleep Medical History

Date: ________________________

Patient Name_____________________________________ ☐ Male ☐ Female Age:________

Nationality: ☐ White ☐ Black ☐ Indian ☐ Asian ☐ Hispanic Other__________________

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 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

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.

Situation	Score
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 drivers 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 beverage ☐ 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 sleep walk? ☐ Yes ☐ No Have you had any injuries?_________________________

Do you have: ☐ High blood pressure ☐ Heartburn ☐ Night sweats ☐ Nasal congestion
☐ Irregular heart beat on awakening ☐ Morning headaches ☐ Dry mouth
☐ Broken your nose ☐ Poor concentration ☐ Swelling in ankles/feet

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 no 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

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Have you ever smoked? ☐ Yes ☐ No If yes, do you still smoke? ☐ Yes ☐ No
If no, when did you quit?________
If you have smoked or still smoke, How many years have you smoked? _________
How many packs a day do/did you smoke?___________

How much alcohol do you drink?_____________________

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Are you ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation_______________________________ Do you work variable shifts? __________

Are you disabled? ☐ Yes ☐ No

Family History: Father ☐ alive ☐ deceased age ______Causes of death ____________
Mother ☐ alive ☐ deceased age ______Causes of death ____________

Is there a family history of sleep apnea? ☐ Yes ☐ No Who___________

Is there a family history of narcolepsy? ☐ Yes ☐ No Who__________