Name:_____ **Age:**_____ **Gender:** Male □ Female □

Date of Birth (month/day/year): ____/____/_____

Race: _____ **Marital Status:** Never married□ Married□ Divorced□ Widowed□

Home Address:_____**City:**_____**ZIP:**_____

Daytime Phone: (____)_____**Evening Phone:** (____)_____

Cell Phone:_____ **Email:**_____

How did you hear about us? _____

Referring Doctor:_____**Address**:_____

Main Sleep Problem: (check all that apply)		**Snoring**	□
Sleepiness or feeling tired	□	**Difficulty falling asleep**	□
Breathing stops during the night	□	**Bed partner making you seek help**	□
Difficulty staying asleep during night	□	**Other:**_____	□

Please describe your sleep problem(s) including both nighttime and daytime symptoms:_____

_____

_____

How long have you had these problems?_____

Please describe any past professional evaluations or treatments for your sleep problems, including what was and was not helpful? _____

_____

What have you tried on you own to improve your sleep and was it helpful?_____

_____

Have you had a sleep study before? (Where? When?)_____

Please check any of the following activities that you do in bed:

Read □ Watch TV □ Eat □ Talk on the phone □ Listen to music □

Write □ Argue □ Worry □ Watch the clock □ Use computer □

How many pillows do you sleep with?_____

Is your bed and bedroom comfortable, dark and quiet? Yes □ No □

Do you do shift work or work during the night? Yes □ No □

Who is your current employer?_____

What is your current occupation/job title?_____

Who do you live with/ sleep with?_____

What types of exercise do you do?_____**How often?**_____

_____

Current height?_____Weight?_____Weight 1 year ago?_____Weight 5 years ago?_____

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:
Sitting and reading Would never doze □. Slight chance of dozing □. Moderate chance of dozing □. High chance of dozing □.
Sitting inactive in a public place (theater, meeting, etc.) Would never doze □. Slight chance of dozing □. Moderate chance of dozing □. High chance of dozing □.
As a passenger in a car for an hour without a break Would never doze □. Slight chance of dozing □. Moderate chance of dozing □. High chance of dozing □.
Lying down to rest in the afternoon when circumstances permit Would never doze □. Slight chance of dozing □. Moderate chance of dozing □. High chance of dozing □.
Sitting and talking to someone Would never doze □. Slight chance of dozing □. Moderate chance of dozing □. High chance of dozing □.
Sitting quietly after lunch *without* alcohol Would never doze □. Slight chance of dozing □. Moderate chance of dozing □. High chance of dozing □.
In a car, while stopped for a few minutes in traffic Would never doze □. Slight chance of dozing □. Moderate chance of dozing □. High chance of dozing □.

Sleep Symptoms

When trying to sleep how often do you experience the following:	**Daily**	**Weekly**	**Monthly**	**Rarely**	**Never**
Difficulty *falling* asleep?					
Trouble *staying* asleep?					
Repeated awakenings?					
Waking up *too early*?					
Snoring or trouble breathing?					
Choking or gasping for air?					
Morning headaches?					
Dry mouth?					
Fall asleep at work					
Have others say you stop breathing at night?					
Sleep talking					
Sleep walking					
Leg, arm or body jerks?					
Tired or crampy legs when you awaken					
Unpleasant feeling in arms or legs just at night					
Other bothersome behaviors?					
Irresistible desire to move legs?					
Kept awake because of bed partner?					
Muscle weakness during intense emotions?					
Intense visual images when falling asleep?					

_____

Awakening Symptoms

When waking up from sleep how often do you notice the following:	Daily	Weekly	Monthly	Rarely	Never
coughing or choking?					
shortness of breath?					
an irregular or rapid heart beat?					
nasal congestion or runny nose?					
stomach acid taste?					
heart burn?					
dry mouth?					
headache?					
anxious or panicky feeling?					
legs, arms or body moving or jerking?					
bed covers extremely messy?					
momentary confusion?					
vivid or frightening visual images?					
temporarily unable to move your body?					

Daytime Symptoms

During the day when you want to be alert and awake how often do you experience:	Daily	Weekly	Monthly	Rarely	Never
Feeling tired even after a full night's sleep					
Struggling to stay awake					
Difficulty concentrating					
Dozing off (even if for a second)					
Trouble remembering					
Stress, anxiety or sadness					
Avoiding social situations					
Not enjoying fun activities					
Daytime sleepiness					
Sudden muscular weakness with strong emotion					

_____

Do you have a regular bed partner? Yes ☐ No ☐

Bed Partner Questions

If possible please have your bed partner (or anyone who has observed your sleep recently) help answer the below questions. They may observe changes the person sleeping cannot notice.

When asleep do others observe:	**Daily**	**Weekly**	**Monthly**	**Rarely**	**Never**
Snoring?					
Loud breathing or sighing?					
Breathing become labored?					
Long pauses between breaths?					
Breathing stop?					
Repeated kicking of legs?					
Repeated moving of arms?					
Thrashing or moving of the body?					
Teeth grinding?					
Sleep walking?					
Sleep talking?					
Other behaviors? Please describe:					
Do any of the above result in sleeping in separate beds?					

On a scale of 1-10 (10 being loudest) How loud can the snoring be?	1	2	3	4	5	6	7	8	9	10

Use the below space to have your bed partner describe any additional information, concerns or problems they feel should be included for evaluation: _____

_____

_____

_____

Sleep-Wake Schedule

The below questions about sleep and wake schedules recognize patterns can vary from day to day. Do not worry about being exact, these are just your best estimates.

Do you keep a fairly regular schedule? Yes □ No □

What time do you go to bed? _____AM/PM.

What time do you get out of bed? _____AM/PM.

Once in bed how long does it take to fall asleep?_____.

Once asleep, how many times do you wake up?_____.

How much lost sleep from awakenings (in minutes)**?** Typical_____. Most_____.

What usually cause you to wake up?_____

What time do you get out of bed to start the day? _____AM/PM.

Total number of hours of sleep at night? _____.

Do you awaken refreshed and ready to begin the day?

Always □ Almost always □ Sometimes □ Rarely □ Never □

How long does it typically take until you are fully awake (in minutes)**?**_____.

How often do you take naps? Daily □ A few days a week □ A few days a month □ Rarely/Never □

If you nap, how long are your naps?_____.

When you are free to choose your own schedule (vacations, weekends etc.), when do you prefer to go to sleep?_____**AM/PM. When do you prefer to wake-up?**_____**AM/PM.**

Many commonly used substances can affect sleep. Please describe your use of the following over the last month.

If you drink **Caffeinated** beverages (including coffee, tea, sodas etc.) please list your daily consumption.

Weekday:_____ . **Weekend:** _____.

If you drink **Alcoholic** beverages (including wine, beer, liquor) please list your daily consumption.

Weekday:_____ . **Weekend:** _____.

If you use **Tobacco** products (include cigarettes, cigars, snuff, chew etc) list your daily use.

Weekday:_____ . **Weekend:** _____.

Mood altering drugs including stimulants (such as cocaine, amphetamine), tranquilizers, and hallucinogens (including marijuana, LSD, or Ecstasy) can affect both sleep and daytime alertness. If you have tried such drugs please list and describe any effects on sleep or daytime alertness: _____

_____

_____

_____

General Medical History

Do you currently have or have you ever been diagnosed with (check any that apply):

High blood pressure	☐	Elevated cholesterol	☐	Diabetes	☐
Heart disease	☐	Lung disease	☐	Liver disease	☐
Heart attack	☐	Abnormal heart rhythm	☐		
Kidney disease	☐	Head trauma or concussion	☐	Reflux (GERD)	☐
Neurologic disease	☐	Seizure disorder	☐	Immune disorder	☐
Kidney disease	☐	Thyroid disease	☐	Arthritis	☐
Stroke	☐	Fibromyalgia	☐	Depression	☐
Anxiety/ panic disorder	☐	Drug abuse/dependence	☐	Alcoholism	☐

Please list any other health problems: _____

_____

_____

_____

Please list the names of healthcare providers for whom you are currently receiving care, or have seen in the past year (If possible include the city where they practice)_____

_____

_____

_____

Please describe any past surgeries or hospitalizations:_____

_____

_____

_____

Please list the medications, vitamins, herbs, and supplements you have taken in the last month. Please include both prescription and over-the-counter medications:

Medication	Dosage	Frequency	Reason	Date started

Please describe any allergies, side effects or other adverse reactions to medications.
If none please write in "none: _____

_____

Medical Review of Symptoms:

Do you experience any of the following? (Check mark symptoms)

	Headaches		Shortness of breath		Pain in muscles	
	Vision problems		Abdomen discomfort		Pain in joints	
	Nasal congestion		Diarrhea		Skin problems	
	Difficulty swallowing		Constipation		Feeling depressed	
	Chest pain		Blood in stools		Feeling anxious	
	Heart palpitations		Urinary frequency		Heart burn	
	Wheezing		Incontinence			
	Coughing		Erectile dysfunction			

Family Medical History

Please list blood relatives (parents, siblings, children etc.) who snore, have daytime sleepiness, insomnia, or other sleep problems:_____

_____

Please list blood relatives with medical or psychiatric disorders: _____

_____

_____