Patient Name: _____ **Date of Birth**: ____/_____/_____

Primary Care Physician: _____ **Referring Physician:** _____

Past Medical History (PMS):

□ Hypertension	□ Asthma	□ Allergic Rhinitis	□ TIA (transient ischemic attack)
□ Diabetes	□ Depression	□ Deviated Nasal Septum	□ Migraines
□ Atrial Fibrillation	□ Anxiety	□ Enlarged tonsils	□ Headaches
□ Congestive Heart Failure	□ Thyroid Disease	□Claustrophobia	□ Seizures
□Coronary Artery Disease	□ Kidney Disease	□ Parkinson's Disease	□ Restless Legs Syndrome
□ COPD	□ Fibromyalgia	□ Suspected Dementia	□ Sleep Apnea in the past
□ Using Oxygen	□ GERD	□ Stroke	□ Using CPAP
□ No Significant Medical History	□PTSD	□Testosterone deficiency	□Sleep Apnea Surgery

Hospitalizations & Surgeries (PSH):

_____

_____

_____

□ **No prior surgeries or procedures**

Family History (Fam Hx):

Have any of your family members been diagnosed with the following? (Please check those that apply)

□ Hypertension	□ Sleep Apnea
□ Diabetes	□ Narcolepsy
□ Atrial Fibrillation	□ Restless Leg Syndrome
□ Stroke or TIA	□ Sleep Walking
□ No Significant Family History	

Please list any additional family history below:

Mother: _____

Father: _____

Brother: _____

Sister: _____

Social History (Social Hx):

Occupation: _____

Working hours: _____am/pm till _____am/pm

# of hours you sit in traffic? _____

Level of Education (please check those that apply):
□ Grade School □ High School □ Vocational □ College □ Masters □ PhD □ MD/ DDS

Are you (please check those that apply):
□ Single □ Married □ Divorced □ Widowed □ Living with Significant Other

Caffeine & Alcohol consumption:
Coffee _____/day Hot chocolate _____/day

Soda _____/day Energy Drinks_____/day

Chocolate _____ /day Tea _____/day

Alcohol (Beer, wine, liquor) _____/day

Tobacco (cigarettes, chewing, cigars):
Do you currently smoke? Yes □ No □

If yes, how many per day? _____

When is your last cigarette at night? _____

Have you *ever* smoked? Yes □ No □

If you no longer smoke, when did you quit? _____

Exercise:

Do you exercise routinely? Yes □ No □

If yes please check each type you do:

□ Walking □ Jogging □Running □Sports □ Weight training □ Other_____

Are you often too tired to exercise? Yes □ No □

Does most of your exercise come from your job? Yes □ No □

Allergies (please list all known allergies and *reaction*):

Environmental or Food Allergies:

_____

_____

☐ No known environmental or food allergies

Drug allergies:

_____

_____

☐ No known drug allergies

Medications:
Please list all medications (prescribed, over the counter and vitamins):

Medications	Dose	Frequency

Immunization History (Immun Hx):
Did you receive a flu vaccine (influenza) in the past year? Yes ☐ No ☐

If yes, please list the date of vaccination: _____

Did you receive a Pneumonia shot (pneumococcal polysaccharide vaccine)? Yes ☐ No ☐

If yes, please list the date of vaccination: _____

Sleep Questionnaire:		
□ Snoring	□ Frequent urination at night	□Loss of muscle tone or paralysis going into sleep or upon awakening
□ Pauses in breathing	□ Bedwetting	□ Falling out of bed
□ Snorting	□ Night sweats	□ Sleep walking
□ Wake up choking or short of breath	□ Un-refreshed upon awakening	□ Nightmares
□ Dry mouth	□ Daytime Sleepiness	□Vivid hallucinations
□ Difficulty falling asleep	□ Fall asleep at unpredictable times	□ Sleep talking
□ Wake up at night; have trouble falling back to sleep	□ Fatigue/tiredness	□ Screaming at night during sleep
□Clock watching	□Frequent refreshing naps	□Night Terrors
□ Frequent awakenings	□ Frequent un-refreshing naps	□ Acting out dreams
□ Waking up too early on most mornings	□ Sleep problems interfere with my life (work, social)	□Loss of muscle tone with laughter or anger or other emotions (cataplexy)
Significant weight change recently? Yes □ No □ □ Gain □ Loss	□ Teeth grinding If yes to teeth grinding do you wear a Mouth Guard? Yes □ No □	□ Waking up in the middle of the night with confusion or disoriented (confusional arousal)

Routine Sleeping Habits:

My bedtime: From_____ am/pm to _____ am/pm;

Weekends: From _____ am/pm to _____am/pm

How long does it take you to fall asleep? _____min/hours

Does your partner snore? Yes □ No □

Is your bedroom environment? **Dark** Yes □ No **Quiet** Yes □ No □ **Comfortable temperature** Yes□ No□

Do you frequently have children or pets in the bed? Yes □ No □

When do you sleep better (Check which one best applies to you): □ Weekdays □ Weekends Vacation

Do you do any of the following in bed:

Watch Television Yes □ No □ Video Games Yes □ No □

Computer Yes □ No □ Cell Phone/ Text Yes□ No □

Restless Legs Symptoms:

Do you have an urge to move your legs when you are sitting or lying? Yes□ No □

If yes, are they worse during evening/ night? Yes□ No □

Are they relieved by movement (stretching, getting-up)? Yes□ No □

Does a bed partner report kicking/sheets in disarray? Yes□ No □

EPWORTH SLEEPINESS SCALE:

This scale refers to your usual way of life in recent times. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? 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.

SCALE:

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

Sitting and reading Situation/Activity Chance of Dozing:	**Scale**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place such as a theater or meeting	
As a passenger in a car for an hour without a break	
Lying down resting in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total score (add all responses)	

Height: _____ **Weight**: _____ **Neck Circumference**: _____

Are you worried or do you have any concerns about sleeping in the sleep center?
Not at all Slightly Moderately Very much

We want you to be very comfortable. What are your concerns?

_____
_____
_____

Sign: _____ **Date: _____**