Sleep History

Patient name: _____ DOB: _____ Age: _____

Telephone: _____ Email: _____

Height: _____ Weight: _____ Gender: _____

Have you ever had a sleep study before? ☐ Yes ☐ No

Where? _____ When? _____

If you have CPAP or OXYGEN at home, what are the settings? _____

Who is your homecare supplies (DME) provider? _____

Who is your primary care physician? _____

Why are you here for a sleep study? Sleep complaints/problems: _____

What time do you usually go to bed? _____

What time do you wake up? _____

How many times do you typically wake up at night, if any? _____

Current medications (or attach list of medications):

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Please list any medication allergies: _____

Do you have any tape or latex allergies? ☐ Yes ☐ No

Do any of your family members have a sleep disorder? ☐ Yes ☐ No

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Do you have any of the following (please check all that apply):

- ☐ None
- ☐ Dry mouth
- ☐ Sweating
- ☐ Need to urinate
- ☐ Panic attacks
- ☐ Nasal congestion
- ☐ Nightmares
- ☐ Choking and gasping
- ☐ Coughing
- ☐ Headache
- ☐ Chest pain
- ☐ Un-refreshed sleep
- ☐ Teeth grinding
- ☐ Heartburn
- ☐ Reflux
- ☐ Body aches
- ☐ Leg discomfort

Medical History (please check all that apply):

- ☐ None
- ☐ CHF
- ☐ Depression
- ☐ Thyroid disorder
- ☐ Head injury
- ☐ Stroke
- ☐ Diabetes
- ☐ Sinus problems
- ☐ Allergies
- ☐ COPD
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Pacemaker
- ☐ Asthma
- ☐ Heart arrhythmia
- ☐ Chronic pain

Please list any other significant medical history and/or surgeries:

_____

_____

_____

Sleep and waking:

1. Are you restless when you sleep? ☐ Yes ☐ No
2. Have you been told you walk or talk in your sleep? ☐ Yes ☐ No
3. Do you act out your dreams? ☐ Yes ☐ No
4. Do you have vivid dream-like experiences in transitions between wake and sleep? ☐ Yes ☐ No
5. Do you experience the inability to move or speak while falling asleep or waking up? ☐ Yes ☐ No

Falling asleep:

1. Are you unable to fall asleep in 15 minutes or less? ☐ Yes ☐ No
2. Do you awaken often while trying to fall asleep? ☐ Yes ☐ No
3. Do you have thoughts racing through your mind while trying to fall asleep? ☐ Yes ☐ No
4. Do you watch a clock or TV while trying to fall asleep? ☐ Yes ☐ No

Sleep Apnea Screening

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations? This refers to how you have been feeling lately. If you have not been in these situations lately, estimate how you feel it would affect you. Please use the following scale to choose the most appropriate number for each situation.

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (in a theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest 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	_____
Score above 10 indicates Excessive Daytime Sleepiness	_____

STOP BANG

S (Snoring)	Do you snore loudly?	☐ Yes	☐ No
T (Tired)	Do you often feel tired, fatigued, or sleepy during daytime?	☐ Yes	☐ No
O (Observed)	Has anyone observed you stop breathing during your sleep?	☐ Yes	☐ No
P (Blood Pressure)	Do you have or are you being treated for high blood pressure?	☐ Yes	☐ No
B (BMI)	BMI more than 35 kg/m?*	☐ Yes	☐ No
A (Age)	Age over 50 years old?	☐ Yes	☐ No
N (Neck Circum)	Neck circumference greater than 40 cm (16 in)?	☐ Yes	☐ No
G (Gender)	Gender male?	☐ Yes	☐ No

**for imperial conversion use lb/in1x 705*
Stensland SH and Margolis S. J am Diet Assoc 1990;90 (60):856

High risk of OSA: **Answering YES to three or more items**
Adapted from Chung F et al Anesthesiology 2008; 108(5): 812-21

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Bed Partner Questionnaire

Name of patient: _____

Date: _____

Name/Relationship of person filling out this form: _____

Please describe any sleep behaviors you have observed in detail. Include a description of the activity, the time during the night when it occurs, frequency it occurs and whether it happens every night:

_____

_____

_____

_____

_____

_____

_____

_____

Have this person ever fallen asleep during normal daytime activities or in dangerous situations? _____

If yes, please explain: _____

_____

_____

_____

_____

_____

_____

Do you have concerns with this person's:

breathing at night?	☐ Yes	☐ No
restlessness during sleep?	☐ Yes	☐ No
sleepwalking/talking?	☐ Yes	☐ No
becoming very rigid or shaking during sleep?	☐ Yes	☐ No