

Sleep 360 Sleep Diagnostic Center

Complete solution to your sleep problems

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Patient Sleep History

Name: -----DOB: -----Date: -----

Height: -----Weight (lbs): -----Neck Size (inches): -----

Referring Physician: ----- Primary Care Physician: -----

Chief Complaint(s):

Describe in detail your sleep problem and how long has this been a problem: -----

What time do you typically go to bed and get up?

Weekdays Bedtime ----- Wake Time -----

Weekends Bedtime ----- Wake Time -----

When you wake up in morning do you feel refreshed? -----Yes -----No

How long does it usually take you to fall asleep once the lights are turned off? -----

Do you awaken during night? -----Yes -----No

How long does it take you to return to sleep upon these awakenings? -----

Do you take naps during the day? -----Yes -----No

If yes, how often? ----- Average length of a nap: -----

Do you feel refreshed after you awaken from these naps? -----Yes -----No

Note the positions you normally sleep in: ---Back ---Right -----Left ----Stomach

Have you been under the care of a cardiologist? -----Yes -----No

Please Mark Appropriate Spaces:

1) Do you snore? -----Yes -----No -----Sometimes

2) Do you snore while lying on your back? ----Yes -----No ----Sometimes

3) Do you snore while lying on your side? ----Yes -----No ----Sometimes

4) Rate your snoring: ----- I do not snore -----Mild -----Moderate -----Loud

5) Do you hold your breath or stop breathing in your sleep? ---Yes ---No ---Sometimes

6) Do you have difficulty breathing while lying on your back? ---Yes ---No -- Sometimes

7) Do you have difficulty breathing while lying on your side? ---Yes ----No---Sometimes

8) Do you wake up with choking sensation or out of breath? ---Yes ---No ----Sometimes

9) Do you have heartburn, indigestion or feel bloated at night? ---Yes---No---Sometimes

10) Do you have night sweats? -----Yes -----No -----Sometimes

11) Do you wake up with a headache? -----Yes -----No -----Sometimes

12) Do you awaken with a dry mouth? -----Yes -----No -----Sometimes

13) Do you have difficulty breathing through your nose? ---Yes ----No ----Sometimes

14) Do you feel sleepy during the day? -----Yes -----No -----Sometimes

- 15) Do you feel fatigued during the day? -----Yes -----No -----Sometimes
- 16) Do you fight sleep while driving? -----Yes -----No -----Sometimes
- 17) Did you have a car wreck caused by sleepiness? -----Yes -----No
- 18) Do you have problems with memory or concentration? ----Yes ----No ----Sometimes
- 19) Do you have impotence or lack of sex drive? -----Yes -----No -----Sometimes
- 20) My family and friends say they have noticed change in personality-----Yes -----No
- 21) Have you had a recent weight gain? ----- If yes, how much? -----
- 22) Have you had a recent weight loss? ----- If yes, how much? -----

- 1) When you awaken from sleep, do you feel paralyzed unable to move even though you are awake? -----Yes -----No -----Sometimes
- 2) When someone startles you or makes you laugh, do you get weak, fall or do your knees buckle? -----Yes -----No -----Sometimes
- 3) While in the process of falling asleep, do you have vivid dreams or hallucinations? -----Yes -----No -----Sometimes
- 4) Do you have frequent uncontrollable bouts of sleep, sleep attacks, or an irresistible urge to sleep? -----Yes -----No -----Sometimes

- 1) Do you grind teeth at night? -----Yes -----No -----Sometimes
- 2) Do your legs twitch or do you kick frequently at night?----Yes ----No ----Sometimes
- 3) Do you experience creepy, crawly, aching, burning or tingling sensation in legs or calves at rest that is better with movement? -----Yes -----No -----Sometimes

- 1) Do you feel irritable/depressed/anxious (circle that apply)? -----Yes -----No ----- Sometimes
- 2) Do you have difficulty falling asleep or maintaining sleep? -----Yes -----No -----Sometimes
- 3) Do you have difficulty falling asleep or maintaining sleep? -----Yes -----No -----Sometimes

- 1) I talk in my sleep -----Yes -----No
- 2) I walk in my sleep -----Yes -----No
- 3) Do you eat in your sleep -----Yes -----No
- 4) Do you act out in your dreams? ----- Yes -----No
- 5) Do you have sleep terrors? ----- Yes ----- No
- 6) Do you have frequent nightmares? ----- Yes -----No

Epworth Sleepiness Scale

Please rate the chances of dozing in the following situations:

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

- Sitting and reading -----
- Watching TV -----
- Sitting inactive in a public place (e.g.; theater or meeting) -----
- As a passenger in a car for an hour without a break -----

Lying down to rest in afternoon -----
 Sitting and talking to someone -----
 Sitting quietly after lunch without alcohol -----
 In a car, while stopped in traffic -----
Total score -----

Sleep Environment

Do you have a bed partner? -----No ----- Yes
 Does your bed partner disturb your sleep? ----- No ----- Yes If so, how?

 Do you disturb sleep of your bed partner? ----- No ----- Yes If so, how?

 Do you use alarm clock to wake up? ----- No ----- Yes
 Do you have pets in your bedroom? -----No -----Yes
 Is your bedroom temperature cool and condusive to sleep? ----- No ----- Yes
 Is your mattress comfortable? ----- No ----- Yes
 Do you work / read/ watch TV/ work on computer in bedroom? -----
 (Circle all that apply)

Fatigue Severity Scale (FSS)

Select a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that he statement applies to you. A low value (e.g., 1) indicated strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement. (Check only one)

My motivation is lower when I am fatigued
 ---0 ---1 ---2 ---3 ---4 ---5 ---6 ---7

Exercise brings on my fatigue
 -----0 ----1 ----2 ----3 ----4 -----5 ----6 -----7

I am easily fatigued
 ----0 ----1 ----2 ----3 ----4 ----5 ----6 ----7

Fatigue interferes with my physical functioning
 ---0 ---1 ---2 ---3---4-----5 ---6 ---7

Fatigue causes frequent problems for me
 ---0 ---1 ---2 ---3 ---4 ---5 ---6 ---7

My fatigue prevent sustained physical functioning
 ---0---1 ---2 ---3---4---5---6---7

Fatigue interferes w/carrying out certain duties
 ---0 ---1 ---2 ---3 ---4 ---5 ---6 ---7

Fatigue is among my three most disabling symptoms
 ---0 ---1 ---2 ---3 ---4 ---5 ---6 ---7

Fatigue interferes w/my work, family, or social life
 ---0 ---1 ---2 ---3 ---4 ---5 ---6 ---7

Total Score: _____

Social History

Do you currently smoke? -----How many packs/day? ----- How many years? -----
Did you smoke in the past? ----- How much? ----- How long? -----
Do you drink alcohol? ----- How much? ----- How often? -----
Do you drink caffeinated beverages? ----- How much? ----- How often? -----
Are you: Single ----- Married ----- Widowed ----- Divorced -----
Are you: Employed ----- Unemployed ----- Retired -----
Employment type:
-----I am a shift worker on rotating shifts.
-----I am a long-term night shift worker.
----- I am currently a student.
----- My job requires me to drive long distances.
----- My job requires me to fly to different time zones.
Do you exercise regularly? ----- If yes, how often? -----
Do you have unusual eating habits? ----- If yes, explain -----
What is your work schedule? _____

Past Medical History

-----Hypertension	----- Heart Disease
----- Diabetes	----- Stroke
----- Peripheral Vascular Disease	----- Acid Reflux Disease
----- Anemia	----- Heart Attack
----- Anxiety / Depression	----- Bipolar Disorder
----- Psychosis / Schizophrenia	----- Asthma
----- Emphysema	----- Congestive Heart Failure
----- Cancer	----- Sinus Problems
----- Prostrate Problems	----- Thyroid Disorder
----- Liver Problems	----- Seizures
----- Tonsillectomy	----- Nasal Surgery
----- Nasal Fracture	----- Seasonal Allergies
----- Laser Surgery for Snoring	----- Chronic Pain
-----Post Traumatic Stress Disorder (PTSD)	-----Traumatic Brain Injury (TBI)
----- Hypothyroidism	----- Atrial Fibrillation
----- Kidney Disease	----- Heart failure

List Other Medical Problems: -----

No known Drug Allergy

Allergies: -----

No known Surgical History

Past Surgical History

List All Surgeries:

Year:

No known Current Medication

Medications

Name	Dose	Reason
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----

Review of System (Circle all that apply)

Constitutional Systems

Fever Chills Malaise Night sweats
Changes in appetite

HEENT

Double vision Wearing glasses Wearing contact lenses Visual changes
Headache Nasal discharge Abnormal sneezing Nose bleeds Postnasal drip
Problems with speech Blurry Vision Nasal congestion Hearing Loss
Problems with swallowing Sore Throat

Respiratory

Dry Cough Cough with sputum Shortness of breath at rest Shortness of breath
with exertion
Congestion Asthma
Wheezing

Cardiovascular

Heart murmur Chest pain Palpitations Edema Skipped beats
Shortness of breath when lying flat

Gastrointestinal

Nausea Vomiting Diarrhea Constipation Abdominal pain Acid Reflux Disease

Genitourinary

Painful urination Menstrual problems Blood in urine Excessive nighttime urination
Urinary frequency Urinary leakage with cough

Psychiatric

Anxiety Depression Psychosis Irritability/mood changes

Neurological

Numbness or tingling on hands or feet Loss of strength

Musculoskeletal

Arthritis or joint pains

Endocrine

Heat/cold intolerance Hair changes Skin becoming dryer
Changes in neck size or appearance Glandular or hormone problem

Hematologic/Lymphatic

Anemia Easily bruising/bleeding

Integumentary

Changes in skin color Changes in hair or nails Rashes Varicose veins Itching

No known Family History

Family History

Children: How many? ----- Ages ----- Health -----

Mother: Living -----yes ----- No If yes, age: ----- Health -----

Father: Living -----yes -----No If yes, age: ----- Health -----

Brothers: How many? ----- Ages ----- Health -----

Sisters: How many? ----- Ages ----- Health -----

Do members of your family have sleep problems? If so, please describe: -----

Do you have any other information to add? -----

Thank you for taking time to answer all the questions

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