Sleep Symptoms & History

In your own words, please tell us what brings you to the sleep clinic today?

How long have you been experiencing your sleep problems? _____yrs._____mos.

To give us a precise understanding of your sleep problem(s), please answer the following questions to the best of your ability:

Insomnia

1. Do you have difficulty falling asleep at night? No Yes → _____ nights/ wk
2. Do you have difficulty staying asleep at night? No Yes → _____ nights/ wk
3. Do you wake up earlier in the morning than you prefer, unable to sleep longer? No Yes → _____ nights/ wk
4. Do you wake up feeling unrefreshed in the morning? No Yes _____nights/ wk
5. Do you feel your sleep difficulty interferes with your daytime functioning? No Yes → _____ days/ wk
6. Are you able to sleep during a nap, if given the opportunity? No Yes
7. Do you have a worried or overactive mind at night when you can't sleep? No Yes
8. Do you currently do any shift work (evenings/overnights)? No Yes → How long? _____ yrs _____mos
9. Within the last year, has depression, anxiety or significant stress interfered with your ability to sleep? No Yes
10. Do you worry about becoming physically or psychologically dependent on sleep medications? No Yes N/A

Fatigue & Sleepiness

11. Do you feel excessively **sleepy or drowsy** during the day? No Yes → If yes, how many days per week?_____ If yes, what time(s) of the day do you feel sleepy?(_i.e. morning, early afternoon)
12. Do you feel physically **fatigued** during the day? (low energy but not drowsy)? No Yes If yes, how many days per week?_____ If yes, what time(s) of the day
13. Do you sleep 12 hours or more at a time? No Yes → How often? _____
14. Have you fallen asleep uncontrollably (like a "sleep attack"), including in inappropriate situations? No Yes → How often? _____
15. How often do you nap? _____days per week. How long typically?_____

Sleep Apnea

16. Do you snore? (circle)
    Never Occasionally Frequently Always I don't know
    If you have a bed partner, please ask your partner to rate how loud you snore:
    1 2 3 4 5 6 7 8 9 10
17. Have you ever been told you stop breathing in your sleep? No Yes
    If "yes" how often: ____ Every night Or ____ Times/Wk Or ____ Occasionally
18. Have you experienced any weight gain over the past months or years?
    No Yes → _____ lbs since _____ (yr)
19. Have you ever woken yourself up snorting or gasping for air? No Yes →
    How often?_____
20. Do you wake up with your heart beating rapidly or irregularly? No Yes →
    How often?_____
21. Do you wake up with a burning throat sensation or with a stomach acid taste, coughing or choking? No Yes → How often?_____
22. Do you wake up with a dry mouth or sore throat? No Yes → How often? _____
23. Do you wake up with a headache? No Yes → How often? _____

Restless Legs

24. Do you experience an uncomfortable feeling in your legs with an urge to move your legs?
    No Yes → How often? _____
25. Does moving your legs give you a sense of relief from these uncomfortable feelings ?
    No Yes → How often? _____
26. Has your bed partner complained about you moving your legs in your sleep?
    No Yes → How often? _____

Unusual Behaviors

27. Have you ever felt sudden muscle weakness when you laughed, gotten angry, were surprised, or during sex? No Yes → How often? _____
28. Have you ever been unable to move your body just as you were falling asleep or waking up? No Yes → How often? _____
29. Have you ever had visual hallucinations or vivid dreams just as you were falling asleep or waking up? No Yes → How often? _____
30. Do you walk in your sleep? No Yes → How often? _____
31. Do you have frequent nightmares ? No Yes → How often?_____
32. Do you grind or clench your teeth at night ? No Yes → How often? _____

Do you have a bed partner? No Yes → **Has he/she said anything about how you sleep?**

_____

_____

Tell us about your typical sleep pattern over the past month:

On Weekdays:

Bedtime:	Time of Final Awakening:	Time You Get Out of bed:

On Weekends:

Bedtime:	Time of Final Awakening:	Time You Get Out of bed:

Typically:

About how many nights per week do you have trouble **falling** asleep at the start of the night? _____ How many nights per week do you have trouble **staying** asleep ? _____
How long does it take you to fall asleep at the start of the night? _____min _____hours
How many times do you wake up during the night ? (not counting your final awakening) _____
After you've first fallen asleep, how much **total time** are you awake for the remainder of the night? _____min _____hours
How many restroom trips do you have on a typical night ? _____
Are you disturbed by pain or physical discomfort in bed ? _____

Have you ever had a sleep consultation or sleep study in the past? No Yes

Consultation (year) _____ Most recent Sleep Study (year) _____

Doctor's Name:_____

Sleep Clinic Name: _____

Do you have the reports to bring to your appointment ?_____

(Please bring in any reports you may have)

Are you currently using or prescribed to use CPAP/BIPAP/APAP/ ASV/ Dental device for sleep apnea ? _____**If yes, please bring all your equipment including power cord to appointment.**

Do you use Supplemental Oxygen? Y N If yes, how many liters/min?

Medical History

Do you have any of the following medical conditions? (Check all that apply)

High Blood Pressure		**Asthma/ Chronic Bronchitis**		**Depression / Bipolar Disorder**		**Parkinson's Disease**	
Stroke / TIA		**COPD or Emphysema**		**Anxiety**		**Alzheimer's or other dementia**	
Coronary Artery Disease		**Acid Reflux (GERD)**		**PTSD:**		**Bladder Disorder**	
Atrial Fibrillation (ever)		**High cholesterol or triglycerides**		**Migraine Headaches**		**Enlarged Prostate**	
Pacemaker		**AutoImmune Disease**		**Frequent Headaches**		**Diabetes (Type 1)**	
Congestive Heart Failure		**Chronic Pain**		**Multiple Sclerosis**		**Diabetes (Type 2)**	
Other Heart Disease:		**Chronic Fatigue Syndrome**		**Fibromyalgia**		**Peripheral Neuropathy**	
Thyroid Disease		**Cancer (type)_____**		**Glaucoma**		**HIV**	

Please list any major illnesses or conditions:	**Year**

Please list any surgeries:	**Year**

What SLEEP Medications are you CURRENTLY taking? Include over the counter & supplements Check here if none ( )

Name	**Dosage**	**Frequency Per Day**	**Time Of Day Taken**

What OTHER medications are you CURRENTLY taking? Include over the counter & supplement? (Please use the back if necessary)

Name (prescription and over the counter)	Dosage	Frequency Per Day	Time Of Day Taken

☐ **Additional medications listed on back**

Medication Allergies or Sensitivities:

Lifestyle Factors

Work

What are your work hours?
Mon – Fri __ am/pm to __ am/pm **Sat**__ am/pm to __ am/pm **Sun** __ am/pm to __ am/pm

Do you currently smoke tobacco? No Yes
If "Yes," how long have you smoked? _____ Years
If "Yes," how much do you smoke in 24-hours ? ____ Packs ___Cigarettes_____Vaping
Have you smoked in the past? No Yes → _____Years

Do you drink caffeinated beverages (Coffee, Tea, Energy drinks, Soda) No Yes
If "Yes," how many (8 oz) cup/ cans of caffeinated beverages do you drink per day? _____

Do you regularly drink alcohol? No Yes If "Yes," how many drinks per day on a typical **weeknight** ? _____ Beer ____ Wine _____Shots
If "Yes," how many drinks on a typical **weekend night**? ___ Beer ___ Wine ___ Shots

Do you use cannabis products? If "Yes," how many times per week ?_____

Exercise Activity: None _____times a week How long? _____ min/workout
Type(s) of exercise:

Do you feel depressed?	Never	Occasionally	Frequently	Always
Do you feel anxious?	Never	Occasionally	Frequently	Always

Are you currently seeing a psychiatrist, psychologist or counselor? No Yes

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in everyday situations in recent times? (Not just feeling tired, but actually dozing off or fall asleep) Even if you have not done some of the activities listed below, try to determine how they might affect you.

Use the following scale to choose the most appropriate number for the situation:

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

For each of the situations listed below, circle the number that best corresponds with your answer.

SITUATIONS	**CHANCE OF DOZING OR FALLING ASLEEP (0 - 3)**
Sitting and reading	0 1 2 3
Sitting inactive in a public place (theater, meeting, etc)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when circumstances permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in Traffic	0 1 2 3
Watching TV	0 1 2 3
Total Score:	