

Please complete this FIRST page as soon as possible and hand it back to the receptionist right away.



Name: _____

Please state in your own words the reason you and/or your doctor referred you to our Sleep Disorders Center:

How long have you had your sleep problem? _____

Have you had a sleep study before? Yes No If yes, where and when? _____

Are you currently using CPAP? Yes No Which company provided the CPAP machine? _____

Are you on oxygen? Yes No If yes, how much? _____

Which company provides your oxygen? _____

Please list any medications you are taking, and the dosage (OR please give us your list and we will copy it):

Please list any major illnesses, chronic conditions or diseases, surgeries or hospitalizations you have had (& if known, the year): _____

Have you had any injuries, including head injuries or loss of consciousness? (if known, please list the year):

Do you have a history of seizures? Yes

Do you have a history of lung disease (i.e., asthma, COPD)? Yes

Do you have a history of acid reflux/GERD? Yes

Sleep Hygiene and Sleep Schedule



On average,
 What time do you go to bed on weekdays? _____ Weekends _____

How long does it take you to fall asleep on weekdays? _____ Weekends _____

What time do you wake up on weekdays? _____ Weekends _____

Sleep Symptoms

	Never	Sometimes	Every day/night
1. I awake feeling rested and refreshed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I snore loudly.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I fall asleep while driving.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I stop breathing during sleep.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I wake up short of breath or feeling choked....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I have dry mouth in the morning.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I have morning headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I have an uncontrollable urge to sleep during the day.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I have to move my legs or arms to get relief from cramps, crawling or aching feelings.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I am unable to fall asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I wake up during the night and cannot get back to sleep.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Watch the clock while trying to fall asleep.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I have racing or busy thoughts while trying to fall asleep.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I sleep better when away from home.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes		
15. I have nightmares	<input type="checkbox"/>		
16. I act out my dreams	<input type="checkbox"/>		
17. I sleepwalk	<input type="checkbox"/>		
18. I talk in my sleep	<input type="checkbox"/>		
19. I grind my teeth	<input type="checkbox"/>		
20. I sleep with the television/radio/light on	<input type="checkbox"/>		

Do you work nights/swing shifts? Yes If yes, what hours: _____

Do you drink coffee or tea? Yes If yes, how much? _____ Cups per day

Do you drink caffeinated soft drinks? Yes If yes, how much? _____ Cans/Bottles/cups per day

Do you drink alcohol? Yes (If yes, how much?) _____

Do you take any recreational drugs? Yes

Do you currently chew tobacco, smoke or vape? Yes If yes, how many years? _____

Did you previously chew tobacco, smoke or vape Yes When did you quit? _____

If you smoke/chew: Which most accurately reflects your current level of use?

- Mild (1/2 pack or less cigarettes a day, 1 can/pouch per week)
- Moderate (1 pack of cigarettes a day, 1 can/pouch bag per day)
- Heavy (2 packs of cigarettes a day, 2 cans/pouches per day)



SLEEP AND BREATHE SPECIALISTS

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your normal every-day life. 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:

Note from Dr. Bird: This scale is not as effective when people consider their busy lives. I suggest imagining you have no job, no school, no family and no responsibilities. You are in a place with no need to hurry, no requirement to stay awake. Please answer the questions as if you could safely sleep without worries.

0 = no chance of dozing

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g a theater or a 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	_____

TOTAL: _____/24