Name:_____ Age:_____

Date of Birth:_____ Sex: □ M □ F Weight:_____ Height:_____

Home Telephone # (_____)_____ Work Telephone # (_____)_____

Marital Status:_____

Referring Physician:_____

Spouse and /or Emergency Contact(s)

_____

Name Relationship Phone # ( )

_____

Name Relationship Phone # ( )

Occupation:_____Years in this job?_____

Are you a shift worker? □ YES □ NO

SLEEP AND WAKE BEHAVIOR ASSESSMENT

1. What are your major complaints related to sleep and wakefulness?

_____

_____

_____

2. How long have you had them?_____

SLEEPINESS ASSESSMENT

1. Are you excessively sleepy during the day? □ YES □ NO

2. Do you fall asleep or have to fight sleep under the following conditions?

Sitting quietly	□ YES	□ NO
Driving	□ YES	□ NO
Riding	□ YES	□ NO
Talking	□ YES	□ NO
Eating	□ YES	□ NO
Standing	□ YES	□ NO
Talking on the telephone	□ YES	□ NO

3. Do you take scheduled naps during the day? □ YES □ NO

_____

Printed Name of Physician Signature

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SYMPTOMS DURING SLEEP ASSESSMENT

1. Check any of the following symptoms that you currently have when sleeping or trying to sleep:

□ Toss & turn	□ Fall out of bed	□ Bed wetting
□ Heartburn	□ Sour belches	□ Pain
□ Regurgitation	□ Night Sweats	□ Teeth grinding
□ Cold feet	□ Sleep walking	□ Sleep talking
□ Nightmares	□ Leg jerking	□ Irresistible urge to move legs

2. Check any of the following that you experience during sleep:

□ Choking	□ Making whistling sounds	□ Gasping for air
□ Loud snoring	□ Struggling to breathe	□ Stop breathing
□ Snorting	□ Sleeping while mouth open	
□ Waking yourself with snoring	□ Waking with a dry mouth	

3. Do you snore in all positions? □ YES □ NO

4. If not what positions do you snore in?_____

SLEEP HABITS ASSESSMENT

1. What time do you usually go to bed?_____

2. How long does it usually take you to fall asleep?_____

3. How many times do you awaken at night?_____

4. Why do you awaken at night?_____

5. Do you have trouble returning to sleep? □ YES □ NO

6. What time do you usually get wake up in the morning?_____

7. How do you wake up in the morning? (i.e., alarm clock, etc.)_____

8. Do you usually sleep longer when you don't have to get up? □ YES □ NO How long?_____

9. How many hours of actual sleep time do you think you get each night on the average?_____

10. Upon awakening in the morning, do you feel:

Completely rested	□ YES	□ NO
Partially rested	□ YES	□ NO
Not rested at all	□ YES	□ NO

11. Do you frequently have a headache during the night and morning? □ YES □ NO

12. Do you take anything to aid in sleep? □ YES □ NO What?_____

NARCOLEPSY ASSESSMENT

1. As you fall asleep or wake up, do you have vivid or lifelike visions (people in the room, etc.) ? □ YES □ NO

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2. When you are angry or excited, do you have sudden weakness or have any part of your body go limp. (head drop, knees buckle, etc.) □ YES □ NO

3. As you are trying to go to sleep or wake up, do you ever have an inability to move? □ YES □ NO

4. Have you ever driven or traveled somewhere and did not remember how you got there? □ YES □ NO

PREVIOUS TREATMENT ASSESSMENT

1. Have you ever been treated for your sleep problems? □ YES □ NO

2. Explain:_____

_____

_____

_____

PSYCHOLOGICAL ASSESSMENT

1. Check any of the following symptoms that you have to an excessive degree:

□ Fatigue
□ Anxiety
□ Suicidal
□ Change in personality
□ Inability to concentrate
□ Depression
□ Family Problems
□ Memory Impairment
□ Irritability
□ Loss of appetite

MEDICAL HISTORY ASSESSMENT

1. Do you have high blood pressure? □ YES □ NO

2. Have you ever had problems with or surgery on your tonsils, adenoids, nose or throat? □ YES □ NO
If yes, please explain:_____
_____

3. Do you have a thyroid condition? □ YES □ NO

4. List any chronic medical condition that you have:

A._____ B._____
C._____ D._____
E._____ F._____

5. List any surgery or injuries and dates that you have had:

A._____ B._____
C._____ D._____
E._____ F._____

6. List any medication to which you are allergic to:

A._____ B._____
C._____ D._____
E._____ F._____

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7. List any medications and dosages that you take on a regular basis. Please include over the counter medications and/or herbs.

_____

_____

_____

_____

8. When was your last complete physical examination?_____

by whom?_____

9. Was blood work performed? □ YES □ NO

10. Have you had thyroid function studies performed? □ YES □ NO

11. Has your weight changed recently? □ YES □ NO

If yes, please explain:_____

SOCIAL AND FAMILY HISTORY ASSESSMENT

1. Do you currently smoke? □ YES □ NO
   If yes, how long?_____

2. Did you previously smoke? □ YES □ NO
   If yes, how long?_____

3. Do you drink alcohol? □ YES □ NO
   If yes, how long?_____

4. How much coffee, tea or cola beverages do you drink per day?_____

5. How many people live in your home? _____

   Relationships to you:_____

6. Does any family member (parent, brother, sister, child, etc) have a sleep problem or snore loudly? □ YES □ NO
   Please Describe:

_____

_____

_____

_____

_____

7. Last grade of school completed. □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ 12 □ 13 □ 14 □ 15 □ 16

_____

Patient/Guardian/Power of Attorney/Patient Representative Signature (Please state relationship)

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