

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 | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Driving | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Riding | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Talking | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Eating | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Standing | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Talking on the telephone | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

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

Printed Name of Physician

Signature



Affix Patient Label Here

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:
- | | | |
|--|---|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Inability to concentrate | <input type="checkbox"/> Memory Impairment |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Suicidal | <input type="checkbox"/> Family Problems | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Change in personality | | |

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. _____ |



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)

