

What is your main sleep problem? _____
 How long have you had this problem: _____
 Please list any previously diagnosed sleep disorders: _____

Check any of the following that apply:

- Loud snoring
- Breathing or snoring stops for brief periods in my sleep
- Awaken gasping for breath
- Do not feel restored when I awaken
- Difficulty falling asleep
- Difficulty remaining asleep
- Awaken too early
- Become sleepy during the day (please check any/all that apply)
 - sitting talking
 - riding eating
 - driving standing
- I have had an automobile accident as a driver.

Sleep Environment

My bedroom is (loud quiet) and (light dark).
 My mattress is (soft hard just right).
 Do you go to sleep with the television on?
 Is your sleep disturbed because of your bed partner or others in your household (children or pets)? Yes No

Occupation

What do you usually do at work?
 How does your sleep problem affect your work?

Weight **Collar Size**
 now: 1 yr. ago: 5 yrs. ago: now: 1 yr. ago: 5 yrs. ago:

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 usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would affect you. Use the following scale to choose the **most appropriate** number for each situation.

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

Situation:

- Sitting and reading
- Watching TV
- Sitting, inactive, in a public place (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 with someone
- Sitting quietly after a lunch without alcohol
- In a car, while stopped for a few minutes in traffic

Total

Indicate, ON AVERAGE, how often you experience the following symptoms:

Times Weekly	Symptoms	Times Weekly	Symptoms
	My mind races with many thoughts when I try to fall asleep		Sudden weakness or feel your body go limp when you are angry or excited
	I often worry whether or not I will be able to fall asleep		Irresistible urge to move legs or arms
	Fatigue		Creeping or crawling sensation in your legs before falling asleep
	Anxiety		Legs or arms jerking during sleep
	Memory impairment		Sleep talking
	Inability to concentrate		Sleep walking
	Irritability		Nightmares
	Depression		Fall out of bed
	Awaken with a dry mouth		Heartburn, sour belches, regurgitation, or indigestion which disturbs sleep
	Morning headaches		Bed wetting
	Pain which delays or prevents sleep		Frequent urination disrupting sleep
	Pain which awakens me from sleep		Teeth grinding
	Vivid or lifelike visions (people, in room, etc) as you fall asleep or wake up		Wheezing or coughing disturbing sleep
	Inability to move as you are trying to go to sleep or wake up		Sinus trouble, nasal congestion or post-nasal drip interfering with sleep
			Shortness of breath disrupting sleep

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Patient Identification

Please be as accurate as possible.

Indicate AM or PM.

If your schedule changes during the week, indicate Your schedule using the "shift work" column.

Activity	Usual schedule	Weekends	ShiftWork
Lay down in bed			
Lights out			
I usually fall asleep in (minutes, hours)			
How many times do you I awaken each night?			
# of times you have difficulty returning to sleep			
Total time I spend awake in bed			
Final wake up from sleep			
What time do you usually get out of bed from sleep?			
How many hours of sleep do you get on average?			
If you take naps, how long?			
Begin work time?			
End work time?			

Other comments:

Medical History Please check if you have any of the following:

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Vision problems
<input type="checkbox"/> Asthma/	<input type="checkbox"/> Seizures	<input type="checkbox"/> Skin condition
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Head injury	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Brain surgery	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anemia	
<input type="checkbox"/> Depression	<input type="checkbox"/> Thyroid condition	
<input type="checkbox"/> Other psychiatric disorder:		
<input type="checkbox"/> Heart disease: CHF, Heart failure, Myocardial infarction (MI) Heart attack, Pacemaker, other:		
<input type="checkbox"/> Prior surgeries:		
<input type="checkbox"/> Other medical problems:		

Medications:

Do you take anything to help you sleep? Yes No If yes, what? _____

List current medication and dosages, including both prescription and over the counter medications:

If you are on oxygen, how much? _____ liter/min. How many hours a day: _____

Drug allergies (please list):

Social History

Do you smoke? Yes No Did you previously smoke? Yes No Do you dip or chew? Yes No

How many years of smoking? _____ How much per day? _____

Do you drink alcohol? Yes No How much? _____ drinks per (day/week/month)

How much caffeinated coffee, tea, or cola do you drink daily?

Family History (please check all that apply)	Sleep Apnea	Heavy Snoring	Narcolepsy	Insomnia	Restless Leg Syndrome	Other Sleep Disturbances
Is there a family history of:						
Mother						
Father						
Sister(s)						
Brother(s)						
Grandparents						

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