Adult Sleep History

Patient Name: _____ Preferred Name:_____

Date of Birth: _____ Date of Appointment: _____ Date this form completed: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Other Phone:_____

Referring Provider Name and Address:_____

Primary Care Provider Name and Address:_____

Person Completing this form: _____ Relationship to patient: _____

Describe your concerns about your sleep:_____

_____

_____

_____

Have you had a sleep study before? ____ YES ____ No

If so, **where** and **when?** _____

Do you have or use at night:

☐Oxygen- Liters per minute: ___
- ☐24/7?
- ☐Night use only?
- Prescriber: _____

☐CPAP
☐BiPAP
☐ASV/Other
☐Bite guard

Durable Medical Company (DME): _____

MRN Sticker (with BARCODE)

Please answer these questions to help us understand your sleep problems. If possible, get help from someone who has seen you sleep (spouse, bed partner, friend, family) to answer these questions:

SLEEP/WAKE ROUTINE

Workdays:
Bedtime: _____ ☐PM ☐AM
Wake time: _____ ☐AM ☐PM

Do you wake up feeling rested?
☐YES ☐NO

Shift work? ☐YES ☐NO

Days Off:
Bedtime: _____ ☐PM ☐AM
Wake time:_____ ☐AM ☐PM

Do you wake up feeling rested?
☐YES ☐NO

Naps:
Number per day: _____
What time of day and how long:
_____
Do you wake up feeling rested?
☐YES ☐NO

Within 4 hours of bedtime do you use: ☐Caffeine ☐Nicotine ☐Alcohol ☐Marijuana ☐Recreational Drugs ☐None

Other substances: _____

What type of caffeine do you use daily?: ☐None ☐Coffee ☐Energy Drinks ☐Soda ☐Tea ☐Other:_____

Timing and amount of caffeine use daily?:_____

How long does it take you to fall asleep? _____ ☐Minutes ☐Hours

How many times do you wake up at night? _____

What wakes you up? _____

How long does it take you to fall back to sleep? ____ ☐Minutes ☐Hours

How many hours do you sleep on average? ____ Hours

What is Your Preferred Sleep Position: ☐Side ☐Back ☐Stomach

SLEEP ENVIRONMENT PLEASE MARK AN "X" NEXT TO THE STATEMENTS THAT APPLY:

- ☐ My bedroom is quiet when I sleep.
- ☐ My bedroom is dark when I sleep.
- ☐ My bedroom is a comfortable temperature.
- ☐ My mattress is comfortable.
- ☐ I feel secure in my bedroom.
- ☐ My pet usually sleeps on my bed.
- ☐ I usually read in bed.
- ☐ I usually listen to music or radio in bed.
- ☐ I usually watch television (TV) in bed.
- ☐ I use a computer/screen/phone in bed.
- ☐ I share a bed with someone.
- ☐ My bed partner snores.
- ☐ My bed partner has a sleep disorder.
  What disorder: _____
- ☐ I sleep worse in my bedroom at home.
- ☐ I sleep worse outside of my bedroom at home.
- ☐ I sleep worse when not sleeping at home.
- ☐ I frequently check the time when I have trouble sleeping.
- ☐ I need an alarm clock to wake up.

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YOUR SYMPTOMS DURING SLEEP (PLEASE MARK AN "X" NEXT TO THE STATEMENTS THAT APPLY:)

- ☐Snoring
- ☐Waking gasping for breath or choking
- ☐Stop breathing or hold your breath while sleeping
- ☐Sweating excessively while sleeping
- ☐Wet the bed while asleep
- ☐Get up to urinate /use the bathroom ____ times per night
- ☐Unable to sleep on back
- ☐Feeling short of breath when lying down
- ☐Waking with acid reflux
- ☐Waking with a sore throat
- ☐Waking with your heart racing or skipping beats
- ☐Often waking with a headache
- ☐Often waking with nausea or wanting to vomit
- ☐Often waking with dry mouth
- ☐Often have trouble falling asleep due to shortness of breath or coughing
- ☐Waking confused and disoriented
- ☐Grinding teeth while asleep
- ☐Vivid dreamlike experiences when waking or falling asleep
- ☐Frequent sleep walking
- ☐Frequent sleep talking
- ☐Feeling paralyzed or unable to move for a short period when waking or falling asleep
- ☐ I "act out" my dreams
- ☐Frequent nightmares
- ☐Weak knees or sagging of the jaw with laughter or strong emotions
- ☐Restless sleep
- ☐Unable to keep legs still prior to falling asleep
- ☐Irresistible urge to move legs when lying down
  - ☐The urge is worse at night
  - ☐The urge is relieved by movement such as getting up and walking around
- ☐Often have difficulty falling asleep due to sadness or depression
- ☐Often have difficulty falling asleep due to feeling anxious or afraid
- ☐Often have difficulty falling asleep due to racing thoughts
- ☐Often have difficulty falling asleep due to pain
- ☐Problems with relationships or social interactions because of sleepiness
- ☐Problems with work or school because of sleepiness
- ☐Problems with concentration and memory because of sleepiness
- ☐Problems with falling down because of sleepiness
- ☐I feel depressed
- ☐I feel anxious or nervous
- ☐I have erectile dysfunction
- ☐I have difficulty controlling my blood pressure
- ☐I have difficulty controlling my diabetes/blood sugar
- ☐I have swelling in my lower legs or feet

FAMILY SLEEP HISTORY (MARK AN "X" NEXT ANY OF THE BELOW THAT **BLOOD RELATIVES HAVE OR HAD**)

	Father	Mother	Brother	Sister	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Children	None
Excessive Sleepiness										
Insomnia										
Restless Legs										
Sleep Apnea										
Sleep Walking/Night Terrors										
Snoring										
Sudden Infant Death										

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EPWORTH SLEEPINESS SCALE

These questions ask how likely you are to DOZE OFF in certain situations. By dozing off we mean falling asleep, not just feeling tired or fatigued.

This refers to how sleepy you felt **within the last 2 WEEKS**. If you have not had these things recently, try to IMAGINE how sleepy you would feel in these situations. Use the following scale to mark and "X" next to the most appropriate number in each situation:

0 = I would NEVER doze off

1 = I would have a SMALL CHANCE of dozing off (about 10% of the time)

2 = I would have a MEDIUM CHANCE of dozing off (about half of the time)

3 = I would have a HIGH CHANCE of dozing off (almost every time)

Chance of Dozing

☐0 ☐1 ☐2 ☐3 Sitting and reading
☐0 ☐1 ☐2 ☐3 Watching TV
☐0 ☐1 ☐2 ☐3 Sitting, inactive in a public place (such as in a theater, meeting, classroom, or church)
☐0 ☐1 ☐2 ☐3 As a passenger in a car for an hour without a break
☐0 ☐1 ☐2 ☐3 Lying down for a rest in the afternoon when circumstances permit
☐0 ☐1 ☐2 ☐3 Sitting and talking to someone
☐0 ☐1 ☐2 ☐3 Sitting quietly after a lunch without alcohol
☐0 ☐1 ☐2 ☐3 In a car, while stopped for a few minutes in traffic (while at the wheel)

FUNCTIONAL OUTCOMES OF SLEEP QUESTIONAIRE (Please mark "X" as appropriate):

	I don't do this activity for other reasons[0]	No difficulty[4]	Yes, a little difficulty[3]	Yes, moderate difficulty[2]	Yes, extreme difficulty[1]
Do you have difficulty concentrating on the things you do because you are sleepy or tired?					
Do you generally have difficulty remembering things, because you are sleepy or tired?					
Do you have difficulty operating a motor vehicle for SHORT distances (less than 100 miles) because you become sleepy or tired?					
Do you have difficulty operating a motor vehicle for LONG distances (greater than 100 miles) because you become sleepy or tired?					
Do you have difficulty visiting with family, friends in their home because you become sleepy or tired?					
Has your relationship with family, friends or work colleagues been affected because you become sleepy or tired?					
Do you have difficulty watching a movie or videotape because you become sleepy or tired?					
Do you have difficulty being as active as you want to be in the EVENING because you are sleepy or tired?					
Do you have difficulty being as active as you want to be in the MORNING because you are sleepy or tired?					
Has your desire for intimacy or sex been affected because you are sleepy or tired?					

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MEDICATION LIST

Please include **CURRENT** prescribed medications, over-the-counter medications and supplements, **including anything you take to help you sleep or help you stay awake**.

Name of Medication	Strength	How Often		Name of Medication	Strength	How Often
Example: Vitamin D3	*5000 units*	*Once per day*				

PAST MEDICAL HISTORY

Do you HAVE NOW, or have you EVER HAD (PLEASE MARK AN "X" NEXT TO ALL THAT APPLY):

- ☐ Acid reflux (GERD)
- ☐ Allergies
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Brain injury
- ☐ Cancer
- ☐ Chronic pain
- ☐ Coronary artery disease
- ☐ Dentures
- ☐ Depression
- ☐ Diabetes
- ☐ Drug abuse
- ☐ Emphysema / COPD
- ☐ Erectile dysfunction
- ☐ Excessive drug use
- ☐ Excessive alcohol use
- ☐ Fibromyalgia
- ☐ Head injury
- ☐ Heart attack
- ☐ Heart failure
- ☐ Heart murmur
- ☐ Heart surgery
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Injury to nose
- ☐ Kidney disease
- ☐ Lung surgery
- ☐ Mental illness
- ☐ Obesity
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Schizophrenia
- ☐ Seizures / Epilepsy
- ☐ Sinus problems
- ☐ Stroke
- ☐ Tonsillitis
- ☐ Tuberculosis

Please list ANY OTHER MEDICAL PROBLEMS not mentioned above: _____

_____

SURGICAL HISTORY

OPERATIONS: Please list surgery types and approximate dates here:

Approximate Date	Type of Surgery
Example: 1/12/2020	*Example: gall bladder surgery*

MRN Sticker

FAMILY HISTORY (PLEASE MARK AN "X" NEXT ANY OF THE BELOW THAT **BLOOD RELATIVES HAVE OR HAD)**

	Father	Mother	Brother	Sister	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Children	None
Alzheimer's										
Arthritis										
Asthma										
Autoimmune Disease										
Birth Defects										
Blood Disorder										
Clotting Disorder										
Developmental Disability										
Diabetes										
Environmental-Seasonal Allergies/Eczema										
ETOH/Drug Abuse										
Gallbladder Disease										
GI Disease										
Glaucoma										
Gout										
Headaches										
Heart Disease										
Hepatitis										
High Cholesterol										
HIV/AIDS										
Hypertension										
Immune Deficiency										
Liver Disease										
Lung Disease										
Mental Illness										
Muscular/Skeletal Disorders										
Pancreas Disease										
Renal Disease										
Seizures										
Stroke										
TB										
Thyroid Disease										
Breast Cancer										
Colon Cancer										
Ovarian Cancer										
Prostate Cancer										
Skin Cancer										
Uterine or Cervical Cancer										
All negative										
History Unknown										

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SOCIAL HISTORY

EMPLOYMENT
- ☐Full-time
- ☐Part-time
- ☐Retired
- ☐Student
- ☐Unemployed
- ☐Other:

ACTIVITY LEVEL

- ☐Desk or Sedentary
- ☐Occasional Physical Work
- ☐Moderate Physical Work
- ☐Heavy Physical Work
- ☐Hazardous Work

EDUCATION

- ☐High School without degree
- ☐High School Degree / GED
- ☐Some College
- ☐College Degree
- ☐Post Graduate Degree

TOBACCO HISTORY

- ☐Never
- ☐Yes, every day smoker
- ☐Yes sometimes smoker
- ☐Secondhand smoke exposure
- ☐Former smoker
- ☐Use nicotine patch, gum, lozenge
- ☐Use e-cig or vape
- ☐Declines to answer
- ☐Unknown

How Many / Day: _____

How Many Years: _____

EXERCISE

FREQUENCY
- ☐Rarely
- ☐1-2 times / week
- ☐3-4 times / week
- ☐5-6 times / week
- ☐Daily

CONDITION
- ☐Poor
- ☐Fair
- ☐Good
- ☐Excellent

TYPE
- ☐Walking
- ☐Running
- ☐Yoga
- ☐Sports
- ☐Other:

ALCOHOL USE

- ☐Never
- ☐Current
- ☐Past
- ☐Other

Type
- ☐Beer
- ☐Wine
- ☐Liquor
- ☐Other

How Much: _____

How Often: _____

HOME ENVIRNOMENT

Do You Live

- ☐Alone
- ☐Significant Other
- ☐Spouse
- ☐Adult Children
- ☐Both Parents
- ☐Single Parent
- ☐Siblings

Other:

Where do You Live

- ☐Home/ independent
- ☐Home / assistance
- ☐Nursing Facility
- ☐Hospice
- ☐Homeless / Shelter
- ☐Other:

Do you Use

- ☐Ventilator
- ☐CPAP
- ☐BiPAP
- ☐Walker / Cane
- ☐Oxygen

SUBSTANCE USE

- ☐Never
- ☐Current
- ☐Past
- ☐Other
- ☐IV Drug Use History

Type: _____

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AUDIT-C QUESTIONNAIRE

QUESTIONS					
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have more than 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

REVIEW OF SYSTEMS

PLEASE MARK AN "X" NEXT TO THE SYMPTOMS THAT HAVE OCCURRED OVER THE **LAST 2 WEEKS**:

General:
- ☐ Sweating during sleep
- ☐ Fever
- ☐ Chills

Neurology:
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting

Eyes:
- ☐ Double vision
- ☐ Blurred vision
- ☐ Eye irritation/discomfort

ENT:
- ☐ Ear pain
- ☐ Nose bleeds
- ☐ Stuffy or congested nose
- ☐ Difficulty swallowing
- ☐ Sore throat

Neck:
- ☐ Neck stiffness/pain

Lungs:
- ☐ Wheezing
- ☐ Shortness of breath at rest
- ☐ Shortness of breath with activity
- ☐ Coughing up blood
- ☐ Nighttime cough

Heart:
- ☐ Chest pain
- ☐ Chest tightness/pressure
- ☐ Skipped heartbeats
- ☐ Palpitations
- ☐ Lower extremity edema

Gastrointestinal:
- ☐ Acid reflux/heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Change in bowel habits
- ☐ Blood in stool or black stool

Genitourinary:
- ☐ Frequent nighttime urination
- ☐ Incontinence

Musculoskeletal:
- ☐ Back pain
- ☐ Joint pain
- ☐ Loss of coordination

Immunology/Hematology:
- ☐ Abnormal bleeding
- ☐ Easy bruising
- ☐ Infections

Skin:
- ☐ Rash
- ☐ Skin sores or lesions

Emotional:
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Sadness / blue mood
- ☐ Depression

Please list any medication that you CANNOT TAKE because of allergy or side effects: _____

_____

Please list any other SENSITIVITIES you have (such as seafood, tape, latex):_____

THANK YOU FOR COMPLETING THIS FORM!

MRN Sticker