SLEEP MEDICINE

VALLEY VIEW HOSPITAL

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SLEEP HISTORY

Confidential Record: Information contained herein will not be released unless you have authorized us to do so.

LAST NAME **FIRST NAME** **MIDDLE NAME**

BIRTH DATE **SEX** **AGE** **HEIGHT** **WEIGHT** **MARITAL STATUS**
M F

STREET ADDRESS **CITY** **STATE** **ZIP CODE**

MEDICARE NUMBER **SOCIAL SECURITY NUMBER**

HEALTH INSURANCE COMPANY **POLICY NUMBER** **GROUP NUMBER**

WHO WAS THE DOCTOR THAT REFERRED YOU FOR A SLEEP STUDY?

EMPLOYER **OCCUPATION**

PATIENT'S PRIMARY CONTACT NUMBER: (_____) _____ Home Cell Business

PATIENT'S SECONDARY CONTACT NUMBER (_____) _____ Home Cell Business

- Please describe your sleep problem(s) *in your own words*. Please be as specific as possible.

  (*For example*, "My bed partner can't sleep because of my snoring." "I sometimes fall asleep unintentionally." "My bed partner says I stop breathing in my sleep." "I have trouble going to sleep at night." "I'm sleepy most of the time." "My bed partner says my legs jerk off and on through the night." "I often awaken with heartburn or choking on stomach acid," etc.)

  _____
  _____
  _____
  _____
  _____

- When did your sleep problem(s) begin? _____
- Has your weight changed in the past 5 years? NO CHANGE *OR*
  YES, I have **gained** about _____ lbs. *OR* I have **lost** about _____ lbs. over the past 5 years.

1. TYPICAL SLEEP HABITS

- What time do you usually go to bed? _____AM___PM___
- What time do you usually get up? _____AM___PM___
- How many hours sleep do you get in a typical night? _____
- When you awaken in the morning do you usually feel refreshed? YES NO
- When your schedule allows you to sleep as late in the morning as you wish, ***how many total hours*** will you sleep? _____
- Do you nap during the day or in the evening before going to bed? YES NO
  If *YES*, how many times per week? _____
  How long is your typical nap? _____
  Do you usually feel refreshed following a short nap? YES NO
- Do you work a night shift or a rotating shift? YES NO
  If *YES*, please describe. _____
  _____
- Is your sleep environment comfortable and quiet? YES NO
- Do you feel unusually sleepy or tired during the day? YES NO

2. DAYTIME SLEEPINESS

The 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 have affected you. Use the following scale to choose the most appropriate number for each situation:

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

Situation	Chance of Dozing
Sitting and reading:	_____
Watching television:	_____
Sitting, inactive in a public place (e.g., theater or 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 quietly to someone:	_____
Sitting quietly after lunch without alcohol:	_____
In a car, while stopped for a few minutes in traffic:	_____
	Total Score:_____

- Please give other examples of what you might be doing when you fall asleep unintentionally.
  *(*For example: *Standing Upright … While Driving … At Work …During Dental Procedures.)*

  _____
  _____

3. ABILITY TO FALL ASLEEP AND MAINTAIN SLEEP

- Does it *typically* take you longer than 30 minutes to fall asleep? YES NO
- Do you *typically* have trouble maintaining sleep (i.e., unable to resume sleep for more than 30 minutes following an awakening)? YES NO

4. BREATHING AND SLEEP

- Have you been told that you snore? YES NO
- Have you been told that you stop breathing (have pauses in your breathing during sleep)? YES NO
- How often you have trouble breathing through your nose? FREQUENTLY OCCASIONALLY RARELY
- Please provide any additional details about your breathing during sleep that you think may be important.

  _____
  _____
  _____

5. REM INTRUSION SYMPTOMS

- Do you sometimes experience dreams just as you are falling asleep? YES NO
- Have you ever experienced sudden muscle weakness (*not dizziness, not fainting*) which made it difficult to stand or difficult to maintain control of your head or arms and hands? YES NO

  If *YES*, was this sudden weakness associated with any particular type of event or emotional state? (**EXAMPLES: laughing, anger, fear, startled**.) YES NO

  If *YES*, please describe the situations that led to these episodes of sudden weakness:

  _____
  _____

- Have you ever experienced an occasion during which you either (1) awoke fully, but found it impossible to move for a minute or so OR (2) felt paralyzed as you were falling asleep? YES NO

  If *YES*, how often does this happen? _____

6. GENERAL SLEEP SYMPTOMS

Restless Legs:

- Do you sometimes have a compelling urge to move your legs, often accompanied by strange, uncomfortable leg sensations such as creepy-crawly sensations, tingling sensations, burning/aching sensations, tugging and/or pulling in the calves? YES NO
- Do these symptoms worsen during periods of rest or inactivity? YES NO
- Does moving your legs provide temporary relief? YES NO
- Do these symptoms become worse, or only occur, in the evening or night? YES NO
- Do you have trouble falling asleep because of your leg symptoms? YES NO
- Do any family members have RLS (Restless Leg Syndrome)? YES NO

Periodic Limb Movements:

Have you been told that you kick or move your legs repeatedly during your sleep? YES NO

Sleep-Related Gastroesophageal Reflux:

- Do you awaken with indigestion/heartburn/sour brash? YES NO

  If *YES*, how often does this happen? FREQUENTLY OCCASIONALLY RARELY

- Do you take antacids or other medicines to *prevent* acid stomach, indigestion, or heartburn that occurs during your sleep? YES NO

  If *YES*, do the medicine(s) you take for acid stomach, indigestion, or heartburn during sleep prevent these problems from occurring? COMPLETELY USUALLY OCCASIONALLY RARELY

- Do you ever awaken with coughing or choking? YES NO

Other:

- Do you feel short of breath when lying down? YES NO

- Do you have unusual behavior while asleep such as sleep walking or violent behavior? YES NO

SURGICAL/DENTAL HISTORY

Have you had any of the following surgeries or procedures?

Tonsillectomy	YES	NO	If *YES*, Approximate Date_____
Nasal Surgery (e.g., septoplasty)	YES	NO	If *YES*, Approximate Date_____
Coronary Bypass Graft(s)	YES	NO	If *YES*, Approximate Date_____
Coronary Angiogram	YES	NO	If *YES*, Approximate Date_____
Coronary Angioplasty	YES	NO	If *YES*, Approximate Date_____
Coronary Stent implantation	YES	NO	If *YES*, Approximate Date_____
Pacemaker implantation	YES	NO	If *YES*, Approximate Date_____
Uvulopalatopharyngoplasty (UPPP)	YES	NO	If *YES*, Approximate Date_____
Laser-assisted Uvulopalatoplasty (LAUP)	YES	NO	If *YES*, Approximate Date_____
Been fitted for an oral appliance for snoring	YES	NO	If *YES*, Approximate Date_____
If *YES*, are you still using this appliance?	YES	NO	
Been fitted for an oral appliance for bruxism(teeth grinding)?	YES	NO	If *YES*, Approximate Date_____
If *YES*, are you still using this appliance?	YES	NO	

Please list any other surgical procedures and give approximate dates:

_____

_____

_____

_____

_____

_____

_____

9. CURRENT HEALTH PROBLEMS

Has a physician told you that you have or had:

- HIGH BLOOD PRESSURE YES NO
- IRREGULAR HEARTBEAT YES NO
- ANGINA YES NO
- HEART ATTACK YES NO
- EMPHYSEMA /COPD YES NO
- CONGESTIVE HEART FAILURE YES NO
- DIABETES YES NO
- ALLERGIES YES NO
- ASTHMA YES NO
- POLIO YES NO
- FIBROMYALGIA YES NO
- DEPRESSION YES NO
- CHRONIC PAIN YES NO
- EPILEPSY YES NO
- PARKINSONISM YES NO
- RESTLESS LEG SYNDROME YES NO
- NEUROPATHY YES NO
- HEADACHES YES NO
- NARCOLEPSY YES NO
- RENAL FAILURE YES NO

Please list any *other* current health problems: _____

_____

_____

_____

_____

_____

10. MEDICATIONS

Please list all current prescription *AND* over-the-counter medications.

NAME OF MEDICATION	AMOUNT (Dosage)	HOW OFTEN TAKEN	REASON FOR TAKING THIS MEDICINE?

11. PRIOR SLEEP STUDIES, PRIOR TREATMENT OF SLEEP DISORDERS

- Have you had a previous sleep study? YES NO

  If *YES*, when was the study done? Month _____ Year _____

  If *YES*, where was the study done? _____

  If *YES*, what was the diagnosis? [**Example:** "Sleep Apnea", "Periodic Limb Movement Disorder"]_____

  What treatment was recommended?_____

- Have you ever been treated for a sleep disorder? YES NO

  If *YES*, please describe the treatment you received. [**Example:** "Put on nasal CPAP at 12 cm pressure."]_____

- Do you have any additional comments that might be helpful to us in understanding your sleep problem?

_____
_____
_____
_____
_____
_____

- Do you smoke? YES NO
- Use other forms of nicotine? YES NO
- Do you use alcohol? YES NO

  If *YES*, on average how many drinks per week? _____

- Do you use caffeinated beverages? YES NO

  If *YES,* on average how many per day? _____

Consent of Sleep Study:

I _____ understand that the Sleep Center at Valley View does conduct Audio
(Please Print Name of the Patient)

and Video Recording for use in clinical evaluation and interpretation of the Sleep Study (Polysomnogram). Any recordings obtained will remain confidential and will be considered a protected portion of my medical record.

_____ _____

(Signature and Date of Patient): (Signature and Date of Polysomnographer):

Thank you for helping us to understand your sleep problem.