# Sleep Innovations

SLEEP SPECIALTY CLINIC

Name: _____ Referring Dr: _____
Age: _____Birthdate: _____Family Dr: _____

**Vitals: (For Nurse's Use Only)**

**Weight:_____Height_____BP:_____Pulse:_____Oximetry:_____**

**Neck Circumference:_____BMI:_____ESS:_____Date:_____Initials:_____**

Please help us find out about you by filling out the **left** side of this form. Please leave the right side blank.

**Have you been evaluated in a sleep clinic previously? YES NO**

**Have you had a sleep study? YES NO**

**If yes, where? _____**

**What was your diagnosis? _____**

**(If you previously had a Sleep Study, please bring them with you to your appointment.)**

**Have you had surgery for either snoring or sleep apnea? YES NO**

**If yes, list type, date and location: _____**

**Do you currently us a CPAP machine? YES NO**

**If yes, do you have a data card? YES NO**

**If yes, please bring your data/SD card with you to your appointment.**

**Why are you here to see a sleep specialist?** **CC:**

_____

_____

_____

**Do you snore?** **HPI:**

- ❑ Yes
- ❑ No
- ❑ Don't know

How long ago did it start?_____

Is it worsening? **Yes** **No**

In which position do you snore?

- ❑ Back only

❑ All positions

Do you snore if you fall asleep in a chair? **Yes** **No**

Has anyone ever noticed if you stop breathing while sleeping?
❑ Yes
❑ No

**Do you suffer from either of the following in the morning?**
❑ Dry mouth
❑ Headache

**Do you feel sleepy during the daytime?**
❑ Yes
❑ No
❑ Don't know
How many days per week?_____
When did it start?_____
Is it worsening? Yes No

**Do you ever dream while you are falling asleep or during naps?**
❑ **Yes**
❑ **No**

**Do you walk or talk in your sleep? Yes No**

**Do you ever accidentally urinate in bed? Yes No**

**Do you have nightmares? Yes No**

**Do you feel sleepy watching TV? Yes No**

**Do you feel sleepy reading? Yes No**

**Have you ever had a close call or accident when driving because of sleepiness? Yes No**

**Do you suffer from memory problems? Yes No**

**Are you more irritable lately? Yes No**

**Do you take any daytime naps? Yes No**
How many per week? _____
How long on average do they last? _____
Are the naps refreshing? Yes No

**How likely are you to doze off or fall asleep doing the following:**

Use the following scale:
1. Would never doze
2. Slight chance of dozing
3. Moderate chance of dozing
4. High chance of dozing

_____ Sitting and reading

_____ Watching television
_____ Sitting inactive in a public place
_____ While a passenger in a car without a break
_____ Laying down to rest in the afternoon when circumstances permit
_____ Sitting and talking to someone
_____ Sitting quietly after a lunch without alcohol
_____ In a car, while stopped in traffic for a few minutes

Epworth score: _____

BMI: _____

**Rate the severity of your sleepiness on a scale of 1 to 10 (1 being No sleepiness and 10 being very severe sleepiness) _____**

**Do you ever experience restlessness or discomfort in your legs?**

❑ Yes
❑ No

When? _____
What do you do to relieve it? _____
How often does it occur? _____
Does it interfere with sleep? Yes No
Do you move or kick your legs while sleeping? Yes No

**Have you ever felt the sudden loss of strength (arms, legs) in response to some emotional experience? Yes No**

**Have you ever felt paralyzed when you first wake up or when you are falling asleep? Yes No**

**Tell us about your sleep schedule.**

What is your bedtime? _____
What time do you get up? _____
How long does it take you to fall asleep? _____
Do you wake up in the middle of the night? Yes No
How many times? _____
Do you fall asleep again easily? Yes No

**Do you use any over the counter or prescribed meds to help sleep?**
**Yes No To keep you awake? Yes No**

**Please list any illnesses you are currently being treated for:**

_____

_____

**Past Medical History:**

**Check off any lung or breathing problems:**

❑ Shortness of breath
❑ Unable to catch your breath
❑ Wheezing
❑ Chest pains or pressure
❑ Coughing up phlegm or blood
❑ Sudden onset of difficulty breathing
❑ Unable to sleep lying flat or with one pillow
❑ Night sweats
❑ Swollen legs
❑ Blue lips or fingernails

- ❑ Leg cramps when you walk
- ❑ Seasonal variation of symptoms
- ❑ Nonproductive cough

**Have you ever had:**

- ❑ Asthma
- ❑ Hay fever
- ❑ Pulmonary function or spirometry test
- ❑ Bronchoscopy or bronchial/lung biopsy
- ❑ Lung surgery, including complete or partial removal
- ❑ Heart surgery
- ❑ Lung cancer or any type of cancer
- ❑ Exposure to tuberculosis or had tuberculosis
- ❑ Positive skin test for TB
- ❑ Pneumonia
- ❑ Blood clot
- ❑ Cardiac Palpitations
- ❑ Atrial Fibrillation

**Have you ever had any operations or injuries?**

**Past Surgical History:**

_____

_____

_____

**Have you had a tonsillectomy or nasal surgery? (please circle)**

- ❑ **Yes**
- ❑ **No**

**Check if any close family member (parents, brothers, sisters, children) has:**

**Family History:**

- ❑ Heart problems
- ❑ Cardiac Palpitations
- ❑ Atrial Fibrillation
- ❑ High blood pressure
- ❑ Diabetes
- ❑ Lung cancer
- ❑ Any other cancer
- ❑ Heartburn
- ❑ Asthma
- ❑ Emphysema
- ❑ Tuberculosis
- ❑ Blood clots
- ❑ Miscarriages
- ❑ Sleep problems in family
- ❑ Other

**Are there any other health problems in your family:**

_____

_____

**Social History:**

**Marital Status: Single Married Widowed Divorced**

**With whom do you live?** _____

**What is your occupation?** _____

**Do you smoke currently, or have you smoked in the past?**

- ❑ **Yes**
- ❑ **No**

**How many packs per day?** _____
**For how many years?** _____
**If you quit, when?** _____

**Do you drink alcohol? Yes No**
If yes, what and how much? _____

**Do you drink coffee, tea, soda or other caffeinated drinks? Yes No**
If so, what and how much per day? _____

**Do you use any recreational drugs? Yes No**

**Have you had the following vaccinations, and when:**

- ❑ Flu Vaccine _____
- ❑ Pneumonia Vaccine _____

**Medications:**

**Please list your medications (names, dosage, how many times per day). Include over-the-counter meds:**

_____

_____

_____

_____

_____

What pharmacy would you routinely use if a prescription needed to be called in for you? _____

**Allergies:**

**Are you allergic to any medications? Yes No**
**If yes, please list and include type of reaction.**

_____

_____

_____

| **Please circle any of the following symptoms you may have:** | **Constitutional:** |
|---|---|
| Lack of energy, daytime sleepiness, trouble sleeping, snoring, loss of appetite, weight changes, fevers | |
| Hearing problems, buzzing or ringing in ears | **HEENT:** |
| Allergies, hay fever | |
| Sinus problems | |
| Blood pressure or heart problems | **Cardiac:** |
| Asthma, tuberculosis | **Pulmonary:** |
| Stomach problems, heartburn, indigestion, change in bowel habits | **Digestive:** |
| Bloody or tarry stools, jaundice, liver problems, ulcers, gallstones | |
| Urinary problems: frequency, infections, stones**,** night-time urination | **Urinary:** |
| Joint pains swelling or redness; arthritis back pain | **Musculoskeletal:** |
| Muscle aches or tenderness, gout | |
| Rash, itching or other skin problems | **Dermatological:** |
| Paralysis, stroke, numbness, loss of balance | **Neurological** |
| Seizures, loss of memory, headaches | |
| Unusual thoughts, nervousness, crying or sadness Depression, suicide attempts | **Psychiatric:** |
| Thyroid disorder, diabetes, excess thirst, hunger or urination | **Endocrinology:** |
| Bleeding, easy bruising, risk factors for HIV, anemia, Cancer | **Hematological:** |

**Patient Signature:**_____ **Date:**_____

**Dr. Signature:** _____ **Date:** _____