North Ottawa Community Health System

NEW PATIENT HISTORY – PATIENT FORM

It is essential that you arrive to your appointment with this <u>form filled out</u> to the best of your ability. Failure to do so may result in delays in your visit. **<u>Please bring in any sleep records</u>** that you may have of previous sleep studies. If you are currently using a CPAP (any type), please bring the SD Card to your appointment if your machine has one.

Personal Information

Name:_____ DOB:_____

Preferred First Name: _____ Email:_____

Phone: Home:(_____)_____ Cell:(_____)_____ Work:(_____)_____

Medications, prescriptions and over the counter (i.e. supplements, birth control, aspirin, and topical) medications:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Sleep Questionnaire

1. Why are you being referred to the Sleep Center?_____

   _____

   _____

   _____

2. Were you referred here by the Department of Transportation or an occupational health physician?

   ❑ YES ❑ NO

3. Have you ever seen a sleep specialist before?

   ❑ YES ❑ NO If yes, for what?_____

4. Do you use Oxygen at home? ❑ YES, _____ liters per minute ❑ during sleep ❑ 24/7
   ❑ NO
5. Have you ever had a sleep study before? ❑ YES ❑ NO
   If so, what were the results? ❑ NORMAL ❑ ABNORMAL
   Where was it performed and when?_____
6. Have you ever been prescribed a CPAP or related machine? ❑ YES ❑ NO
   If yes, what is/was the pressure set to?_____ What mask do you use?_____
   Are you currently using this machine? ❑ YES ❑ NO
   If not, why not?_____
7. What company (DME) provides your CPAP machine, masks, and equipment?_____
8. Are you being considered for bariatric surgery? ❑ YES ❑ NO
9. Are you currently on, or have you tried sleep medications in the past? If so, please list the medication, dosage (if known), dates of use, and how effective they were for you.
   _____
   _____
   _____
10. Are you currently on, or have you ever been prescribed stimulant medications in the past? (example, Ritalin, Provigil) ❑ YES ❑ NO
    If yes, please list the stimulant(s) prescribed:_____
    _____
    Why were they prescribed?_____
11. Do you or your bed partner have a pacemaker or defibrillator? ❑ YES ❑ NO
12. Do you or your bed partner have a metallic hemostatic clip implanted in your head to repair an aneurysm? ❑ YES ❑ NO
13. Do you or your bed partner have metallic splinters in one or both eyes following a penetrating injury? ❑ YES ❑ NO
14. Do you have a spinal cord stimulator? ❑ YES ❑ NO
    If yes, can it be turned off? ❑ YES ❑ NO

FOR FEMALE PATIENTS ONLY:

15. Are you currently pregnant, or do you plan on becoming pregnant in the near future?
    ❑ YES ❑ NO

SLEEP PROBLEM CHECKLIST

The following is a list of symptoms that may be experienced by people with sleep problems. Please check (☑) only the symptoms that you have experienced.

☑ Box

	Snoring with sleep
	My family complains about my snoring
	Waking up with a choking or gasping sensation
	Someone has told me I stop breathing when I sleep
	Dry mouth or sore throat upon awakening
	Headaches upon awakening
	Acid reflux or heartburn that disturbs your sleep
	Nasal congestion, obstruction or discharge at night

	Excessive fatigue or sleepiness
	Fall asleep or doze off unintentionally
	Sleepiness while driving (i.e. falling asleep at red light, stop sign or drifting onto rumble strips)
	Forgetfulness or decreased concentration
	Sudden loss of muscle tone triggered by intense emotion (i.e. surprise, laughter or ange)
	Temporary inability to move or speak while falling asleep or waking up
	Hallucinations when falling asleep or waking up from sleep

	Urge to move legs due to uncomfortable or unpleasant feelings in the legs
	Creeping, crawling or uncomfortable sensation of legs when sitting or before sleep
	Uncomfortable sensation of legs that improves with movement
	Kicking or jerking of legs while sleeping

	Difficulty sleeping or problems at work due to shift work
	Tendency to be a “night owl” or stay up very late
	Tendency to be a “morning lark” or go to bed very early

	Walking while sleeping
	Falling out of bed
	Pounding, punching, kicking or acting out dreams during sleep
	Loud talking or screaming during sleep
	Disturbing dreams
	Have you had any traumatic experiences in the bedroom?
	Night time panic attacks
	Grinding or clenching teeth in your sleep

TYPICAL SLEEP SCHEDULE

Do you take sleep aids? If so, what medication(s) and at what time do you take them? _____ _____	_____am / pm _____am / pm
Over the past month, what has been your bedtime routine? (ex. TV, reading, bath, …..) _____ _____	
Over the past month, what has been your average bedtime (one time)?	_____am / pm
Over the past month, what has been the average time that you wake to start your day (one time)?	_____am / pm
How long does it take you to fall asleep at night (estimated)?	_____minutes
How many hours of sleep do you estimate that you get each night?	_____hours
How many times do you wake-up during the night?	_____times
How long do you estimate that you are awake in total during these awakenings?	_____minutes
How many times do you usually urinate during the night?	_____times
At the end of your sleep period, you awaken:	_____spontaneously _____alarm clock
Do you typically feel refreshed on awakening?	_____Yes _____No
Do you take naps?	_____Yes _____No
If you take naps, please indicate how frequently you nap.	___more than once a day ___once a day ___several days a week ___rarely
What time of day do you usually nap?	_____am / pm
How long are your naps?	_____minutes
Any differences on weekends or days off?_____ _____ _____	

Past Medical History: Check all that apply.

___ Heart Attack (Myocardial Infarction ___ Congestive Heart Failure (CHF) ___ Heart Disease ___ Cardiomyopathy ___ Arrhythmias (Irregular Heart Rhythm) ___ Atrial Fibrillation (A-Fib) ___ High Blood Pressure ___ Pacemaker/Defibrillator ___ Peripheral Edema (swelling in the feet/legs)	___ Migraine ___ Headache ___ Seizure / Epilepsy ___ Multiple Sclerosis ___ Amyotrophic Lateral Sclerosis (ALS) ___ Stroke ___ Transient Ischemic Attack (TIA) ___ Brain Tumor ___ Parkinson's Disease Or Parkinsonism ___ Elevated Intracranial Hypertension (Pseudo Tumor Cerebri) ___ Traumatic Brain Injury (TBI) ___ Neuropathy	___ Type 2 (Adult-Onset) Diabetes ___ Thyroid Disease ___ Chronic Kidney Disease ___ BPH (Enlarged Prostrate) ___ Excessive Night Time Urination ___ Erectile Dysfunction ___ Gastroesophageal Reflux Disease (GERD) ___ Chronic Constipation ___ Chronic Diarrhea
___ Chronic Obstructive Pulmonary Disease (COPD) ___ Emphysema ___ Asthma ___ Allergies		___ Bipolar Disorder ___ Dementia or Cognitive Impairment ___ Memory Problems ___ ADD / ADHD ___ Post-Traumatic Stress Disorder (PTSD) ___ Depression ___ Anxiety ___ Panic Attacks ___ Claustrophobic ___ Other Psychiatric Diagnoses_____ _____ _____
___ Elevated Red Blood Cell Counts/Polycythemia ___ High Cholesterol Or Triglycerides ___ Anemia ___ Low Testosterone ___ Low Vitamin D	___ Chronic infectious disease Please circle any that apply: (MRSA, TB, VRE, Hepatitis, and HIV) ___ Chronic Fatigue Syndrome ___ Fibromyalgia ___ Chronic Pain Location / Type: _____ _____	
___ Floppy Eyelid Syndrome ___ Glaucoma ___ Blindness		

PAST SURGICAL HISTORY

___ Tonsils / Adenoids Removed ___ Uvulopalatopharyngoplasty (UPPP)
___ Nasal / Sinus Surgery ___ Bariatric Surgery ___ Deep Brain Stimulation

Any Other Surgeries:_____

_____

Do you use a walker? ❑ YES ❑ NO

Do you use a wheelchair? ❑ YES ❑ NO

Do you use a cane? ❑ YES ❑ NO

Do you sleep in or need a hospital bed? ❑ YES ❑ NO

Do you experience incontinence? ❑ YES ❑ NO

Do you need a bedside commode or urinal? ❑ YES ❑ NO

Do you need a caregiver to stay with you if you have a sleep study? ❑ YES ❑ NO

Review of Systems

Please indicate if you currently experience any of the following.

General
- ❑ Fatigue
- ❑ Weight Loss
- ❑ Weight Gain
- ❑ Jaw Joint Pain – TMJ

Neurological
- ❑ Headache
- ❑ Insomnia
- ❑ Snoring
- ❑ Restless Legs

Genitourinary
- ❑ Frequent Night time Urination
- ❑ Decreased Libido/Sex Drive
- ❑ Males: Difficulty Maintaining Erections

Musculoskeletal
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Night Time Muscle Cramps

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Memory Loss

Cardiovascular
- ❑ Chest Pain
- ❑ Palpitations
- ❑ Leg Swelling

Skin
- ❑ Rash

Respiratory
- ❑ Cough
- ❑ Shortness of Breath
- ❑ Wheezing

Ear Nose Throat
- ❑ Nasal Congestion
- ❑ Nose Bleeds

Gastrointestinal
- ❑ Acid Reflux/Heartburn
- ❑ Nausea

Social History

Please check: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Children: ❑ None ❑ Yes, living with me ❑ No, not living with me

1. Do you have a Commercial Driver's License?_____
2. Occupation:_____
   Place of Work:_____
   ❑ Full time ❑ Part-time ❑ Retired ❑ Disabled ❑ Unemployed
3. Tobacco Use: ❑ NO ❑ YES If yes, indicate how much_____
4. Alcohol Use: ❑ NO ❑ YES If yes, indicate how much_____
5. Caffeinated Beverage Use: ❑ NO ❑ YES If yes, how much/what time of day
   _____
6. Drug Use: ❑ NO ❑ YES If yes, indicate how often_____
7. Exercise: ❑ NO ❑ YES How often/what time of day_____

Family History

Please indicate illnesses that your first degree family members have but not you. Include their relation to you and approximate age of onset, if known, to the best of your ability.

Medical Condition	*Family Member(s) Affected and Age of Onset*
Snoring	
Sleep Apnea	
Restless Leg Syndrome (RLS)	
Sleep Walking	
Insomnia	
Narcolepsy	

Epworth Sleepiness Scale (ESS)

How likely are you to doze 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 circle 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	Chance of Dozing			
Sitting and reading.	0	1	2	3
Watching television.	0	1	2	3
Sitting, inactive in a public place (at a theater or meeting).	0	1	2	3
As a passenger in a car for an hour without a break.	0	1	2	3
Lying down to rest in the afternoon when circumstance permits.	0	1	2	3
Sitting and talking to someone.	0	1	2	3
Sitting quietly after lunch without alcohol.	0	1	2	3
In a car, while stopped for a few minutes in traffic.	0	1	2	3
Total (nurse to calculate)				

The Fatigue Severity Scale (FSS)

FSS Questionnaire: Please circle from 1 to 7 to indicate how well each statement describes you.

During the past week, I have found that:	Least like me						Most like me
1. My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
2. Exercise brings on my fatigue.	1	2	3	4	5	6	7
3. I am easily fatigued.	1	2	3	4	5	6	7
4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
8. Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7

Average (nurse to calculate):_____

Please note any additional information that you feel would be helpful to the physician.

_____

_____

_____

For Office Use:

This document was reviewed and additional comments made where appropriate by physician.

Physician:_____ Date:_____ Time:_____

Do you regularly have a bed partner? ❑ NO ❑ YES

If yes, please have him/her fill out the information below.

Bed Partner Questionnaire

Patient Name_____Your Name_____ Date_____ Time_____

I have observed this person's sleep: _____Never _____ Rarely _____ Often _____Every Night

Check any of the following behaviors that you have observed this person doing while asleep.

	Light Snoring		Loud Snoring		Moderate Snoring
	Choking		Pauses in breathing How long?_____		Twitching/kicking of legs during sleep
	Grinding teeth		Sleep Walking		Getting out of bed, but not awake
	Bed wetting		Biting Tongue		Actually sleeping even if behaves otherwise
	Crying out		Becoming rigid/shaking		Sitting up in bed, but not awake
	Falling out of bed		Acting out dreams (ex. punching, kicking)		Other_____ _____

Please describe the sleep behaviors checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

_____

_____

_____

_____

_____

_____

_____

Has this person ever fallen asleep during normal daytime activities or in a situation that may become dangerous?

❑ YES ❑ NO If yes, please describe:_____

_____

_____