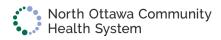


NEW PATIENT HISTORY – PATIENT FORM

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.

Perso	nal Informat	<u>tion</u>		
Name	:			DOB:
Prefer	red First Na	me:		Email:
Phone	e: Home:()	Cell:()	Work:()
	cations, pres	criptions and over	the counter (i.e. supplemen	ets, birth control, aspirin, and topical)
Sleep	Questionna	<u>ire</u>		
1.	Why are yo	ou being referred t	o the Sleep Center?	
2.	Were you	referred here by th	e Department of Transportat	tion or an occupational health physician?
	☐ YES	□ NO		
3.	Have you e	ever seen a sleep s	pecialist before?	
	☐ YES	□ NO	If yes, for what?	





4.	Do you use Oxygen at home?		YES,	_ lite	ers per minute	☐ duri	ing 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 r	elate	ed machine	??	☐ YES		NO	
	If yes, what is/was the pressure set to?		W	hat r	mask do you us	se?		
	Are you currently using this machine?		YES		NO			
	If not, why not?							
7.	What company (DME) provides your CPAP	mac	hine, mask	s, an	nd equipment?			
8.	Are you being considered for bariatric surg	ery?	☐ YE	S	☐ NO			
9.	Are you currently on, or have you tried sleed dosage (if known), dates of use, and how e	•			•	please l	ist the medication,	
10.	Are you currently on, or have you ever bee Ritalin, Provigil)	0						
	Why were they prescribed?							
11.	. Do you or your bed partner have a pacema	ıker	or defibrilla	ator?	YES		NO	
12.	. Do you or your bed partner have a metallic aneurysm?	hen	nostatic cli _l	p im	planted in you YES	r head t	o repair an NO	
13.	. Do you or your bed partner have metallic s	plint	ers in one	or b	oth eyes follow YES		enetrating injury? NO	
14.	. Do you have a spinal cord stimulator?				☐ YES		NO	
	If yes, can it be turned off?				☐ YES		NO	
FΟ	R FEMALE PATIENTS ONLY:							
15.	. Are you currently pregnant, or do you plan	on b	pecoming p	regr	nant in the nea	r future	??	
					☐ YES		NO	





SLEEP PROBLEM CHECKLIST

The following is a list of symptoms that may be experienced by people with sleep problems. Please check (\boxtimes) 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	am / pm				
take them?	am / pm				
	le a le le				
Over the past month, what has been your bedtime routine? (ex. TV, reading,	patn,)				
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	am / pm				
start your day (one time)?					
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	minutes				
awakenings?					
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?	YesNo				
Do you take naps?	YesNo				
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	Migraine	Type 2 (Adult-Onset)					
Infarction	Headache	Diabetes					
Congestive Heart Failure	Seizure / Epilepsy	Thyroid Disease					
(CHF)	Multiple Sclerosis	Chronic Kidney Disease					
Heart Disease	Amyotrophic Lateral	BPH (Enlarged Prostrate)					
Cardiomyopathy	Sclerosis (ALS)	Excessive Night Time					
Arrhythmias (Irregular Heart	Stroke	Urination					
Rhythm)	Transient Ischemic Attack	Erectile Dysfunction					
Atrial Fibrillation (A-Fib)	(TIA)	Gastroesophageal Reflux					
High Blood Pressure	Brain Tumor	Disease (GERD)					
Pacemaker/Defibrillator	Parkinson's Disease Or	Chronic Constipation					
Peripheral Edema (swelling in	Parkinsonism	Chronic Diarrhea					
the feet/legs)	Elevated Intracranial						
Chronic Obstructive	Hypertension (Pseudo	Bipolar Disorder					
Pulmonary Disease (COPD)	Tumor Cerebri)	Dementia or Cognitive					
Emphysema	Traumatic Brain Injury (TBI)	Impairment					
Asthma	Neuropathy	Memory Problems					
Allergies Elevated Red Blood Cell	Chronic infectious disease	ADD / ADHD Post-Traumatic Stress					
		Disorder (PTSD)					
Counts/Polycythemia	Please circle any that apply:	Depression					
High Cholesterol Or Triglycerides	(MRSA, TB, VRE, Hepatitis, and HIV)	Anxiety					
Anemia	Chronic Fatigue Syndrome	Panic Attacks					
Low Testosterone	Fibromyalgia	Claustrophobic					
Low Vitamin D	Chronic Pain	Other Psychiatric					
Floppy Eyelid Syndrome	Location / Type:	Diagnoses					
Glaucoma	Location / Type.	2.08.10303					
Blindness							
PAST SURGICAL HISTORY							
Tonsils / Adenoids Removed	Uvulopalatopharyngoplasty (
Nasal / Sinus Surgery	Bariatric Surgery	Deep Brain Stimulation					
Any Other Surgeries:							
Any other surgeries.		 -					
Do you use a walker?	□ NO						
Do you use a wheelchair?	□ NO						
Do you use a cane?	□ NO						
Do you sleep in or need a hospital be	d? □ 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.

☐ Fatigue☐ Weight Loss☐ Weight Gain		Neurological ☐ Headache ☐ Insomnia ☐ Snoring ☐ Restless Legs		Genitourinary ☐ Frequent Night time Urination ☐ Decreased Libido/Sex Drive ☐ Males: Difficulty Maintaining Erection				
Musculoskeletal □ Back Pain □ Joint Pain □ Night Time Musc	le Cramps	☐ Depression☐ Anxiety		Cardiovascular ☐ Chest Pain ☐ Palpitations ☐ Leg Swelling	<u>Skin</u> □ Rash			
Respiratory ☐ Cough ☐ Shortness of Breath ☐ Wheezing		■ Nasal Con	Ear Nose Throat ☐ Nasal Congestion ☐ Nose Bleeds		<u>ll</u> Heartburn			
Social History								
Please check:	☐ Married	☐ Single	☐ Divorced	☐ Widowed				
	Children:	☐ None	Yes, living	with me	☐ No, not living with me			
			☐ Disabled	☐ Unemployed				
	□ NO	☐ YES						
5. Caffeinated Beve	rage Use:	□ NO	☐ YES	If yes, how muc	h/what time of day			
6. Drug Use:	□ NO	☐ YES	If yes, indicate	e how often				
7. Exercise:	□ NO	☐ YES	How often/w	hat time of day				
Family History								
Please indicate illnes		_	=	-	Include their relation to			
Medical Cond	ition	Fa	mily Member(s) Affected and Ag	ue of Onset			
Snoring								
Sleep Apnea								
Restless Leg Syndro	me (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

Average (nurse to calculate):_____

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.		1	2	3		
Lying down to rest in the afternoon when circumstance permits.		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)						

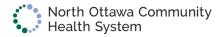
The Fatigue Severity Scale (FSS)

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		
 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	
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	

Please note any additional information that you f	eel would be helpful to the ph	vsician
ricase note any additional information that you i	cer would be helpful to the ph	iyəlciaii.
- 		
For O	ffice Use:	
This document was reviewed and additional of	comments made where approp	oriate by physician.
Physician:	Date:	Time:





Bed Partner Questionnai			
		Date Time	
I have observed this person	on's sleep:Never Rar	rely OftenEvery Nigh	
Check any of the following	g behaviors that you have observed this p	person doing while asleep.	
Light Snoring	Loud Snoring	Moderate Snoring	
Choking	Pauses in breathing	Twitching/kicking of legs during	
	How long?	sleep	
Grinding teeth	Sleep Walking	Getting out of bed, but not awake	
Bed wetting	Biting Tongue	Actually sleeping even if behaves otherwise	
Craing out	Becoming rigid/shaking	Sitting up in bed, but not awake	
Crying out			
Falling out of bed describe the sleep behavio	Acting out dreams (ex. punching, kicking) ors checked above in more detail. Include	•	
Falling out of bed describe the sleep behavio	Acting out dreams (ex. punching, kicking)	e a description of the activity, the time	
Falling out of bed describe the sleep behavio	Acting out dreams (ex. punching, kicking) ors checked above in more detail. Include	e a description of the activity, the time	

