

PATIENT DEMOGRAPHICS AND SLEEP HISTORY

SECTION 1

Personal Information

Date: _____

Name: _____
Last First MI

Sex: _____ *Race:* _____ *Height:* _____ *Weight:* _____ *lbs.*

Please List Allergies, if any: _____

PAIN ASSESSMENT

1. ARE YOU EXPERIENCING PAIN? YES OR NO

IF NO NUMBERS 2 AND 3 DO NOT APPLY.

2. IS PAIN _____CONTINUOUS _____INTERMITTENT

3. RATE YOUR PAIN 0 1 2 3 4 5 6 7 8 9 10

Section 2

Summary Of Your Sleep Elements

1. Describe your sleep problems in your own words:

2. Describe HOW and WHEN this problem began:

3. Describe any treatments you have received for your problem:

4. Has this been a continuous or intermittent problem? (Please Mark)

_____ Continuous, almost every night
_____ Intermittent, occasional problem
_____ Frequent problem

5. How long has your sleep problem been bothering you? (Please Mark)

_____ Longer than 2 years _____ within the 3 months
_____ 1 to 2 years _____ within the last month
_____ Several months

6. Please describe your sleep environment. (How and where you prefer to sleep)

Section 3

Medical History Conditions

1. Please list any chronic present or past medical illness diagnosed by a physician (examples: COPD, Diabetes, Hypertension, Incontinent, etc.)

2. Please list the medications you take on a daily basis. (Prescription and Over the Counter)

<i>Medication</i>	<i>Daily Dosage</i>	<i>Reason for Taking</i>

3. *Approximately how many ounces of the following beverages do you consume daily?*

Natural coffee _____
Alcoholic drinks _____

Colas with caffeine _____
Decaf. Coffee _____

Chocolate _____
Tea _____

4. *Check any of the following that you feel apply to you.*

- | | | | |
|---------------------------|-------------------------|------------------------|----------------------------------|
| <i>Nightmares</i> | <i>Palpitations</i> | <i>Feeling Panicky</i> | <i>Unable to relax</i> |
| <i>Bowel Disturbances</i> | <i>Fainting</i> | <i>Headaches</i> | <i>Dizziness</i> |
| <i>Feeling Tense</i> | <i>Poor Memory</i> | <i>Depression</i> | <i>Difficulty with decisions</i> |
| <i>Shyness</i> | <i>Insomnia</i> | <i>Anxiety</i> | <i>Bad Home Conditions</i> |
| <i>Suicide Ideas</i> | <i>Stomach Problems</i> | | |

Section 3 cont'd

5. *Do you have a family history of snoring or other sleep disorders?* _____yes _____no
If yes, please describe in detail:

6. *Do you breathe easily through your nasal passages?* _____yes _____no

7. *Are you unable to sleep in a flat position due to shortness of breath?* _____yes _____no

8. *Have you ever sustained a concussion, head injury or blow to the head?* _____yes _____no

9. *Do you have spells, seizures or passing out?* _____yes _____no

10. *Do you have or have you ever had high blood pressure?* _____yes _____no

11. *Have you experienced a weight gain in the past year?* _____yes _____no
If yes, how many pounds have you gained? _____lbs.

12. *Do you have home oxygen?* _____yes _____no
If yes, when do you wear it? _____continuously or _____just during sleep?
If so, how many liters of oxygen? _____

13. *Do you have home CPAP or BIPAP?* _____yes _____no
If yes, what is the pressure setting? _____

14. *Have you ever smoked?* ____yes ____no
How many packs per day do you smoke? _____
How many years have you smoked? _____
Do you smoke now? ____yes ____no
15. *Do you drink alcohol?* ____yes ____no
If yes, estimate the number of drinks you have per day: _____ *on workdays:* _____ *on days off.*
16. *Do you drink alcohol after 6:00 pm?* ____Never ____ on Occasion ____ Frequently ____ Always
17. *Do you consume caffeinated drinks?* ____yes ____no *If yes, how many per day?* _____
18. *Do you drink caffeine after 6:00 pm?* ____Never ____ on Occasion ____ Frequently ____ Always

Section 4

Your Sleep Habits

1. *What time do you usually go to bed?* _____ *workdays* _____ *days off.*
2. *What time do you usually wake up?* _____ *workdays* _____ *days off.*
3. *How long does it take you to fall asleep?* _____
4. *How many hours of sleep do you usually get per night?* _____ *hrs.*
5. *How many times do you typically wake up at night?* _____ *Why?* _____

6. *If you wake up, how long do you stay awake before going back to sleep?* _____
7. *Which shift do you work?* ____Days ____Evenings ____Nights
8. *Do you ever rotate shifts?* ____yes ____no *If yes, how often?* _____
9. *Does the nature of your job require overnight travel?* ____yes ____no
10. *Are you able to fall asleep and awaken on a day-to-day and week-to-week basis according to your desired schedule?* ____yes ____no
11. *Do you nap during the day or in the evenings?* ____yes ____no

Section 5 cont'd

Please circle the appropriate response for each of the questions below using the following abbreviations:
NOTE: Your bed partner may be helpful in answering some of the questions.

N = never / no R = rarely O = occasionally F = frequently A = always

The Quality Of Your Sleep

19. *Is your sleep disturbed because of your bed partner or others in the household?* *N R O F A*
20. *Do you snore?* *N R O F A*
21. *If you snore, does your snoring stop for brief periods during the night?* *N R O F A*
22. *Does your breathing sometimes stop during the night?* *N R O F A*
23. *Is your bed partner disturbed by your snoring, If any?* *N R O F A*
24. *Do you have nasal/sinus congestion at night?* *N R O F A*
25. *Do you have nasal strips, sprays, etc.?* *N R O F A*
26. *Do you have morning headaches?* *N R O F A*
27. *Are you a restless sleeper, tossing and turning at night?* *N R O F A*
28. *Do you wake up thirsty or with a dry mouth?* *N R O F A*
29. *Please list any other information you would like for us to know about your sleeping problems.*

30. *If you sleep with a CPAP or BIPAP machine at night, what company provided your machine?*

31. *If not, and following your studies there is a need for such equipment, what company would you prefer to use?*

THANK YOU FOR YOUR COOPERATION

Epworth Scale

Please evaluate how likely you are to fall asleep in the following situations and rate using this scale:

*Would never doze = 0
Slight chance of dozing = 1
Moderate chance of dozing = 2
High chance of dozing = 3*

- _____ *Sitting and reading*
- _____ *Watching television*
- _____ *Sitting inactive in a public place (theater or meeting)*
- _____ *As a passenger in a car for an hour without a break*
- _____ *Laying down to rest in the afternoon*
- _____ *Sitting and talking to someone*
- _____ *Sitting quietly after lunch (when you have had no alcohol)*
- _____ *In a car, while stopped in traffic*

- _____ *Total*

