Sleep History

Patient Name____DOB_______HT_____WT_____

Describe your sleep concerns____

____

What are you hoping to achieve? Treat Snoring__ Better Night Sleep__ Treat Sleep Apnea__

Other____

____

Suspected Sleep Disorder: Sleep Apnea___ Insomnia___ Hypersomnia___ RLS___

Other____

____

Current Medical Conditions:

Coronary Artery Disease	____	GERD	____	Diabetes	____
Congestive Heart Failure	____	Arrhythmia	____	Allergic rhinitis	____
Hypercholesterolemia	____	Chronic pain	____	Hypertension	____
Depression	____	Hypothyroidism	____	COPD	____
Asthma	____	Swelling in ankles or feet	____	ADD/ADHD	____

Other____

____

List all the medications you are taking____

____

History of the following? (Check all that apply)

Snoring	____	Non-refreshing Sleep	____	Frequent Nightmares/Dreams	____
Gasping	____	Choking	____	Trouble staying asleep	____
Nocturnal reflux	____	Fatigue	____	Difficulty falling asleep	____
Restless sleep	____	Jaw pain	____	Teeth grinding	____
Mood disturbance	____	Facial pain	____	Headaches	____
Jaw clicking	____	Cognitive impairment	____	Memory loss	____
Trouble sleeping due to pain	____	Snoring affecting sleep of others	____	Ear Infections	____

Have been told “I stop breathing” when sleeping ____

Urge to move legs or tingling, creeping feelings in legs ____

Please answer the following questions:

Do you have a family history of sleep apnea? Yes_____ No _____

Do you have any lung or breathing problems? Yes_____ No _____

If yes, please describe.____

____

Do you have a pacemaker? Yes_____ No _____

Do you use oxygen at night? Yes_____ No _____

Do you get up to go to the bathroom frequently during the night? Yes_____ No _____

If yes, what is the frequency? ____

Have you ever had oral or nasal surgery? Yes_____ No_____

Do you drink alcohol? Yes_____ No_____

How often? (check all that apply) Daily_____ 3-5 times a week_____ Once a week_____

Only on weekends_____ On special occasions_____

Any recent change in your intake of alcohol? Yes_____ No_____

If yes, please describe: ____

____

Have you had a Sleep Study in the past? Yes_____ No_____

Date_______________ Sleep Center Name and Location____________________________

City__________________________________ State___________ Zip code_______________

Name of your Physician____________________________ Phone______________________