Sleep History

What are you hoping to achieve? Treat Snoring Better Night Sleep Treat Sleep Apnea Other	Patient Name		DOB	_HT	_WT	
Suspected Sleep Disorder: Sleep Apnea Insomnia Hypersomnia RLS Other Current Medical Conditions: Coronary Artery Disease GERD Diabetes Congestive Heart Failure Arrhytmia Allergic finitits 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 Restless sleep Jaw pain Teett grinding asleep Restless sleep Jaw pain Headaches Jaw clicking Cognitive impairment Memory loss 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	Describe your sleep concerns_		· · · · · · · · · · · · · · · · · · ·		 	
Suspected Sleep Disorder: Sleep Apnea Insomnia Hypersomnia RLS Other Current Medical Conditions: Coronary Artery Disease GERD July Dispersor 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 Frequent Nightmares/Dreams Gasping Non-refreshing Sleep Frequent Nightmares/Dreams Gasping Choking Trouble staying asleep Difficulty falling asleep Difficulty falling asleep Difficulty falling asleep Difficulty falling asleep Jaw pain Teeth grinding Headaches Jaw clicking Cognitive impairment Headaches Headaches Sleeping Gue to pain Snoring affecting sleep of others Ear Infections 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 July Page Arrhythmia Headaches Page No Do July Page Arrhythmia Page Page No Do July Page Arrhythmia Page Page No Do July Page Page Page Page Page Page Page Page	What are you hoping to achi	eve? Treat Snoring Better N	ight Sleep	Treat SI	eep Apnea	
Current Medical Conditions: Cornoary Artery Disease	Other					
Current Medical Conditions: Coronary Artery Disease	Suspected Sleep Disorder:	Sleep Apnea Insomnia_	Hyperso	omnia	RLS	
Coronary Artery Disease	Other					
List all the medications you are taking	Coronary Artery Disease Congestive Heart Failure Hypercholesterolemia Depression	Arrhythmia Chronic pain Hypothyroidism		Allergic Hyperte COPD	rhinitis nsion	_ _ _ _ _
History of the following? (Check all that apply) Snoring	Other					
History of the following? (Check all that apply) Snoring	List all the medications you are	e taking				
Do you have a family history of sleep apnea? Yes No Do you have any lung or breathing problems? Yes No	History of the following? (Classing Gasping Nocturnal reflux Restless sleep Mood disturbance Jaw clicking Trouble sleeping due to pain Have been told "I stop breathing"	neck all that apply) Non-refreshing Sleep Choking Fatigue Jaw pain Facial pain Cognitive impairment Snoring affecting sleep of cowhen sleeping		Frequent Trouble : Difficulty Teeth gri Headach Memory	t Nightmares/Drea staying asleep falling asleep nding les loss	ims
Do you have any lung or breathing problems? Yes No	Please answer the following	questions:				
	Do you have a family history o	sleep apnea? YesI	No			
If yes, please describe	Do you have any lung or breat	ning 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