HEALTHSTAR
PHYSICIANS, P.C.

Healthstar Sleep Medicine | Dr. Hina Kouser

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NEW SLEEP PATIENT MEDICAL HISTORY

Name: _____ DOB:_____ Age: _____

Referring Physician: _____PCP: _____

Breifly describe your main sleep problem: _____

How long?: _____

Does this problem affect your daily life? _____

Have you ever had a sleep study? If yes, where/when? _____

Do you currently have a CPAP machine? _____

Where do you get your supplies?_____

Sleep History

1. What is your usual bedtime? _____Weekday wake time?_____ Weekend wake time? _____
2. What is your bestime on days off? _____ Wake time on days off? _____
3. How long does it take you to fall asleep? _____ Do you take sleeping pills? _____
4. How long do you sleep at night on average? _____
5. Do you have many awakenings? If ys, how many on average? _____
   Is there anything that awakens you? _____
6. Do you have difficulty going back to sleep when you awaken during the night? _____
7. What is your work schedule? _____ Are you required to do shift work? _____
8. Do you nap regularly? _____ What time of day and how long? _____
9. Do you snore? _____ How often? _____ How long have you snored? _____
10. Do you seem to stop breathing at night? _____ If so, how often does this happen? _____
11. Do you wake up gasping for air or choking? _____
12. Do you sleep on your back? _____

Sleep History

13. Do you wake up feeling refreshed? _____
14. Are you excessively sleepy during the day? _____ How long? _____
15. Does your work involve driving? _____ Do you fall asleep while driving? _____
16. Do you have an itchy, creepy/crawling sensation in your legs or urge to move your legs? _____
17. Do you grind your teeth? _____
18. Do you talk in your sleep? _____
19. Do you act out your dreams? _____ If yes, describe: _____

    _____
20. Do you experience weakness or loss of muscle control during emotions like laughing, happiness or anger? _____
21. Do you experience sagging of the jaw during emotions like laughing, happiness, or anger? _____
22. Do you wake up and see shadows of people or animals? _____

Medication List

Pharmacy name: _____ Pharmacy phone: _____

NO Allergies ☐ Pregnant or lactating? Yes ☐ No ☐

Allergic to:	Reaction: (hives, itching, anaphylaxis, etc)

Medications

Drug name	Dose	Frequency

Social History

Do you use chewing tobacco?: Yes No

Do you smoke?: Yes No

If yes, How much do you smoke or chew tobacco?: _____

Do you do so close to bed?: _____

Have you ever smoked? Yes No If yes, how long? _____ PPD _____

When did you quit? _____

Do you drink alcohol? Yes No

If yes, how much? _____ Do you do so close to bed? Yes No

How much caffeine do you drink? _____

Do you do so close to bed? _____

Do you have a commercial drivers license? _____ exp date: _____

Review of Symptoms Circle all that apply

General:	fever chills weight change(increase or decrease)
Ear, Nose, Throat	sinus allergies sinus surgeries dentures dry mouth difficulty breathing rhough nose
Heart	heart racing smothering at night
Lung	cough shortness of breath at night
Digestive	adbominal pain nausea vomiting diarrhea heartburn/acid reflux
Bladder	frequent urination in the night
Muscle	back pain leg pain other pain: _____
Skin	rash swelling
Nervous System	morning headaches dizziness seizures previous trauma
Hormonal Disorder	thyroid testing insulin dependent diabetes
Mental Health	depression anxiety claustrophobia memory problems
Blood Disorders	anemia blodd loss iron deficiency

The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How sleepy are you?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not your would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. theater, meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Total score: _____

Interpretation:

0-7: It is unlikely that you are abnormally sleepy.

8-9: You have an average amount of daytime sleepiness.

10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.

16-24: You are excessively sleepy and should consider seeking medical attention.

Reference: Johns MW. A new method for measuring daytime sleepiness. The Epworth Sleepiness Scale. *Sleep* 1991; 14(6):540-5

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Bed Partner / Observer Questionnaire

Circle all that apply.

1. I sleep in the same room as the patient.
2. I sleep in the same bed as the patient.
3. I sleep in a different room.
4. I have noticed no problem with the patient's sleep.
5. I have noticed a problem for _____weeks, _____months, _____ years.
6. I am bothered by the patient's snoring.
7. I am bothered by the patient's not breathing for a short time.
8. I am bothered by the patient's restless arm or leg movement.
9. I notice that the patient may frequently fall asleep inappropriately (while watching TV, reading, etc.)
10. I am bothered by the patient getting up at night.
11. I can not easily awaken the patient in the morning.
12. I have noticed a change in the patient's personality in the past _____weeks, _____months, _____ years. How? _____
13. Other comments: _____

_____