# Intake Form: Sleep

## Chief Complaint

In your own words, what brings you in today?

_____

_____

## History of Present Illness (HPI)

Briefly describe your present symptoms:

_____

_____

Date symptoms began? _____

Describe the frequency of the problem *(continuous, intermittent, daily, hourly etc.)*:

_____

On a scale from 0 to 10, 0 being no problem at all and 10 being severe as possible, how would you rate it? _____

What body parts are most affected? _____

Have you previously received a diagnosis for this problem? *(circle one)* **Yes** **No**

If so, what was the diagnosis:_____

Who made the diagnosis:_____

What tests have been performed to evaluate this problem *(i.e. MRI, lab tests, etc.)*?

_____

_____

What treatments have been tried for this problem *(i.e. medications, physical therapy, etc.)*?

_____

_____

What improves the problem *(medication, rest, sitting, etc.)*?

_____

_____

What worsens the problem *(exercise, poor sleep, stress, etc.)*?

_____

_____

Has your problem interfered with your activities of daily living, such as bathing, feeding, or clothing yourself, or has it impacted your occupation? If so, what?

_____

_____

Who in your family has a similar problem?

_____

Are you interested in participating in research trials? *(circle one)* **Yes** **No** **Maybe**

**Surgical History** ☐ No prior surgeries or procedures

| Procedure | Date (MM/YYYY) | Complications? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Review of Systems

**Constitutional** ☐ None of the below

☐ Fever / Chills
☐ Unintentional weight gain / loss
☐ Exercise intolerance
☐ Fatigue
☐ Night sweats
☐ Inability to sleep
☐ Sleeping too much

**HEENT** ☐ None of the below

☐ Blurred vision / vision loss
☐ Hearing change
☐ Nosebleeds
☐ Difficulty chewing / swallowing
☐ Change in smell / taste
☐ Double vision
☐ Ringing in the ears
☐ Hoarseness / prolonged sore throat
☐ Speech changes / difficulty
☐ Snoring

**Respiratory** ☐ None of the below

☐ Shortness of breath
☐ Wheezing
☐ Chronic cough

**Cardiovascular** ☐ None of the below

☐ Chest pain / pressure / heaviness
☐ Swelling of feet / ankles
☐ Palpitations
☐ Fainting spells

**Gastrointestinal** ☐ None of the below

☐ Nausea / Vomiting
☐ Constipation
☐ Diarrhea
☐ Heartburn / Indigestion
☐ Abdominal pain
☐ Blood in stool

**Genitourinary** ☐ None of the below

☐ Pain or burning with urination
☐ Blood in urine
☐ Sexual dysfunction / impotence
☐ Frequent urination
☐ Change in menstrual cycle

**Neurologic** ☐ None of the below

☐ Headache
☐ Numbness / Tingling
☐ Involuntary movements / tremor / twitching / cramps
☐ Memory loss
☐ Poor balance / falls
☐ Seizures / Convulsions

**Psychiatric** ☐ None of the below

☐ Mood change
☐ Depression
☐ Anxiety
☐ Hallucinations
☐ Paranoia
☐ Delusions

**Endocrine** ☐ None of the below

☐ Heat or cold intolerance
☐ Excessive sweating
☐ Excessive thirst / urination
☐ Hair change

**Hematologic/Immune** ☐ None of the below

☐ Easy bruising or bleeding
☐ Swollen lymph nodes

**Musculoskeletal** ☐ None of the below

☐ Joint pain
☐ Neck pain +/- shooting pain into arms
☐ Low-back pain +/- shooting pain into legs

## Sleep Questionnaire

My main sleep complaint *(check all that apply)*

□ Trouble sleeping at night Duration:_____
□ Daytime sleepiness Duration:_____
□ Snoring Duration:_____
□ Unwanted behaviors during sleep Explain:_____
□ Other Explain:_____

## Sleep Pattern

| | Workdays *(weekdays)* | Off Days *(weekends)* | | Workdays *(weekdays)* | Off Days *(weekends)* |
|---|---|---|---|---|---|
| Typical bedtime | | | Typical amount of time to go back to sleep after awakening | | |
| Typical amount of time it takes to fall asleep | | | Typical wake up time | | |
| Typical number of awakenings per night | | | Desired wake up time | | |
| List any activities that you normally do during nighttime awakening(s) *(i.e. restroom, eat, watch TV)* | | | How do you usually awaken *(i.e. alarm clock)* | | |
| | | | Typical time you get out of bed | | |
| | | | Total amount of sleep per night | | |
| | | | Number of naps per day | | |

## Sleep Habits *check all that apply*

□ I usually watch TV or read in bed prior to sleep
□ I frequently travel across 2 or more time zones
□ I drink alcohol prior to bedtime
□ I smoke before bedtime or when I wake up during the night
□ I eat a snack at bedtime
□ I eat during nighttime awakenings
□ I typically awaken to urinate during sleep
□ I have trouble falling asleep
□ I awaken frequently during the night
□ I have difficulty returning to sleep after awakening during the night
□ I have thoughts racing through my mind when I try falling asleep
□ I awaken early in the morning, still tired but unable to return to sleep
□ I have nightmares as an adult
□ I experience creeping-crawling or tingling in my legs when I try falling asleep
□ I sweat a great deal during sleep
□ I cannot sleep on my back

## Sleep Situation

□ I sleep alone
□ I share a bed with someone
□ I share a bedroom, but have separate beds
□ I share a dwelling, but have separate bedrooms

## Breathing Issues

□ I have been told that I stop breathing during sleep
□ I awaken at night chocking, smothering, or gasping for air
□ I have been told that I snore
□ I have been told that I snore only when sleeping on my back
□ I have been awakened by my own snoring

## Restlessness

□ I am a restless sleeper
□ I kick or jerk my legs and/or arms during sleep
□ I experience a restless, tingling, or crawling in my arms or legs
□ I experience an inability to keep my legs still prior to falling asleep
□ I talk in my sleep as an adult
□ I have sleepwalked as an adult
□ I grind my teeth in my sleep

## Daytime Sleepiness

□ I take daytime naps
□ I tend to fall asleep during the day
□ I have experienced lapses in time/backouts
□ I have fallen asleep while driving
□ I have had auto accidents due to sleepiness
□ I fall asleep during conversations
□ I fall asleep in sedentary situations
□ I performed poorly in school due to sleepiness
□ I have had injuries due to sleepiness
□ I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
□ I have experienced inability to move while falling asleep or waking up
□ I have experienced hallucinations or dreamlike images or sounds when falling asleep or waking up
□ I drink caffeinated beverages during the day
_____ cups/bottles/cans per day

## Employment Status

□ Employed
- □ My job requires driving a vehicle
- □ I work with dangerous equipment or substances
- □ I am a shift worker on rotating shifts
- □ I am a permanent or long term third shift worker
- □ I am currently a student

□ Unemployed
□ Retired

## Past Sleep Evaluation and Treatment

□ I have had a previous sleep disorder evaluation
□ I have had previous overnight sleep studies
□ I have had daytime nap studies
□ I have been prescribed CPAP or BiPAP machine for use at home
□ I have had surgical treatment for sleep disorder
□ I have previously been prescribed a medication for a sleep disorder
□ I have previously been treated for a sleep disorder

## Epworth Sleepiness Scale

How likely are you to doze off 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 have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = would *never* doze

1 = *slight* chance of dozing

2 = *moderate* chance of dozing

3 = *high* chance of dozing

| Situation | Score |
|---|---|
| Sitting and reading | |
| Watching TV | |
| Sitting inactive in public (e.g., theater) | |
| Passenger in a car for 1 hour | |
| Lying down to rest in the afternoon | |
| Sitting and talking to someone | |
| Sitting quietly after lunch (no alcohol) | |
| In a car, stopped in traffic | |
| **Total Score:** | |

**Bedtime Parter Questionnaire**

Name of Patient: _____ Date: _____

*To be completed by bed partner*

Check any of the following behaviors that you have observed the patient doing during sleep:

- □ Loud snoring
- □ Light snoring
- □ Pause in breathing
- □ Sleep talking
- □ Sleepwalking
- □ Sitting up in bed (not awake)
- □ Getting out of bed (not awake)
- □ Kicking during sleep
- □ Twitching of legs/feet
- □ Teeth grinding
- □ Biting tongue
- □ Bed wetting
- □ Head rocking/banging
- □ Becoming rigid/shaking

How long have you observed the behavior(s) listed above?

Describe the behavior(s) checked above in more detail (activity, time of night, frequency during the night, nightly occurrence):

If you have heard loud snoring, do you recall pauses in snoring or loud “snorts”?