Patient Sleep Medical History

Date: _____________

Patient Name______________________________________ ☐ Male ☐ Female DOB: ________

Have you ever been diagnosed with sleep apnea? ______________________________________
Have you ever worn, or do you wear a CPAP or BIPAP device? _____________________________

Do you snore? Yes/No ☐ All night ☐ Periodically ☐ In one position
If positional what position_________________
Intensity of snoring ☐ Mild ☐ Moderate ☐ Severe
Do you awaken gasping or choking? ☐ Yes ☐ No
Do you awaken short of breath? ☐ Yes ☐ No

Do you have apneas (pauses in breathing)? ☐ Yes ☐ No
Who has observed the apneas? ____
Do they awaken you? ☐ Yes ☐ No
Does your bed partner elbow you during sleep because you snore or have pauses in your breathing ☐ Yes ☐ No
How long are the apneas? ____________ How often? _______________

Do you feel sleepy during the day? ☐ Yes ☐ No
Does sleepiness affect your work performance? ☐ Yes ☐ No Explain_________________
Have you fallen asleep at work? ☐ Yes ☐ No
Explain ____
How likely are you to “doze off” or fall asleep in the situations described below?

Using the following scale, select the number that is most appropriate for you and write in the space after each situation.

0 – I would never doze off.
1 – There is a slight chance I would doze.
2 – There is a moderate chance I would doze.
3 – There is a high chance I would doze.

Sitting and Reading __________
Watching television __________
Sitting inactive in public place meeting or classroom __________
As a passenger in a car for 1 hour __________
Lying down to rest in the afternoon __________
Sitting and speaking to someone __________
Sitting quietly after lunch without alcohol __________
In a car while stopped for a few minutes in traffic __________

Do you take naps during the day? ☐ Yes ☐ No Do you feel better? ☐ Yes ☐ No

Have you ever had a motor vehicle accident due to sleepiness? ☐ Yes ☐ No

Do you ever get sleepy while driving? ☐ Yes ☐ No
If yes, what do you do? ____

Do you have a commercial driver’s license? ☐ Yes ☐ No

Do you drink alcohol prior to bedtime? ☐ Yes ☐ No How much? ________ How often? ______

Do you eat before bedtime? ☐ Yes ☐ No How much? ________ How often? ____________

Do you drink caffeinated beverages? ☐ Yes ☐ No How much? _________________
Which: ☐ Coffee ☐ Tea ☐ Soda Pop ☐ Energy drinks When? _________________

What time do you go bed? Weekdays ___________ Weekends_______________
How long does it take for you to fall asleep? __________________________________

What time do you get up in the morning? ______________________________

How often do you awaken during the night? _____________________________

Do you awaken and urinate? _________________ How often? ______________

How many hours of sleep do you usually get a night? ______________________

Do you feel rested when you wake up in the morning? ☐ Yes ☐ No ☐ Sometimes

Do you sleep with a bed partner? ☐ Yes ☐ No

Do you talk in your sleep? ☐ Yes ☐ No

Do you sleepwalk? ☐ Yes ☐ No Have you had any injuries? _________________________

Do you have: ☐ High blood pressure ☐ Heartburn ☐ Night sweats ☐ Nasal congestion

☐ Irregular heartbeat on awakening ☐ Morning headaches ☐ Dry mouth

☐ Broken your nose ☐ Poor concentration ☐ Swelling in ankles/feet

☐ History of Stroke ☐ History of Heart Attack ☐ History of Heart Failure (CHF)

Do you have chronic pain that keeps you from sleeping? ☐ Yes ☐ No
If yes explain____
Do you use street drugs? ☐ Yes ☐ No Explain if yes ______________________________

Do you toss and turn at night? ☐ Yes ☐ No Do you have restless sleep? ☐ Yes ☐ No

Do you kick your feet during the night while asleep? ☐ Yes ☐ No

Have you used any sleeping pills? ☐ Yes ☐ No
Which ones have you tried? ____

Has your weight been stable? ☐ Yes ☐ No
If not, how has it changed? ____

Do you grind your teeth at night? ☐ Yes ☐ No

Do you have restless legs (crawling, achy or inability to keep legs still)? ☐ Yes ☐ No

Is it better with getting up and moving? ☐ Yes ☐ No Is it worse with relaxation? ☐ Yes ☐ No

Is it worse during the course of the: ☐ Day ☐ Early evening ☐ Night

Does it make it difficult to fall asleep? ☐ Yes ☐ No