SLEEP NEW INTAKE

Today's Date: _____

Patient's Name: _____ **DOB:** _____

1. Who is filling out this form? □ Self □ Other _____

2. Please list reason for today's visit: _____

3. Do you have any allergies to medications? □ No □ Yes
If Yes please list the medication, the nature of the reaction & how long ago the reaction was:
_____

4. CURRENT MEDICATIONS:
Please list your current medications:

Drug Name: _____	Dose: _____	Frequency: _____
Drug Name: _____	Dose: _____	Frequency: _____
Drug Name: _____	Dose: _____	Frequency: _____
Drug Name: _____	Dose: _____	Frequency: _____
Drug Name: _____	Dose: _____	Frequency: _____

5. 24 HOUR SLEEP/WAKE PATTERN:	On Weekdays	On Weekends
What time to you go to bed?	_____	_____
How long does it take you to fall asleep?	_____	_____
How many times do you wake up in the middle of the night?	_____	_____
What time do you finally wake up?	_____	_____
Do you wake up refreshed?	_____	_____
Do you take daytime naps?	_____	_____
If yes, for how long?	_____	_____

Who do you sleep with? _____

6. Please circle if you had any of the following in the past 1 week:

Fever	Chills	Fatigue
Headaches	Ear problems	Hoarseness
Chest pain	Fainting	Irregular heartbeat
Heartburn	Vomiting	Abdominal pain
Wheezing	Cough	Difficulty breathing
Seizures	Dizziness	Stroke
Skin rash	Hives	Itchy skin
Joint pains	Joint swelling	Joint redness
Depression	Anxiety	Insomnia
Anemia	Low iron	Blood disorders

Other medical problems _____

7. SLEEP RELATED REVIEW OF SYSTEMS:

Do you have any of the following problems related to sleep?

- Snoring? □ YES □ NO
- Stops breathing at night? □ YES □ NO
- Mouth breathing at night? □ YES □ NO
- Excessive sweating at night? □ YES □ NO
- Walking during sleep? □ YES □ NO
- Talking during sleep? □ YES □ NO
- Falling off bed at night? □ YES □ NO
- Nightmares? □ YES □ NO
- Night terrors? □ YES □ NO
- Teeth clenching or grinding? □ YES □ NO
- Leg jerking or tossing around in sleep? □ YES □ NO
- Bedwetting? □ YES □ NO
- Feeling paralyzed upon waking up? □ YES □ NO
- Hallucinations when going to sleep/waking up? □ YES □ NO
- Headaches upon waking up? □ YES □ NO
- Frequent colds/chest infections? □ YES □ NO

8. Please list any previous medical problems: _____

_____

9. Please list any previous surgeries: _____

_____

10. FAMILY HISTORY: List family members who have any of the following:

- Obesity _____
- High Blood Pressure _____
- Sleep Apnea _____
- Diabetes_____
- Heart Disease _____
- Other _____

11. SOCIAL HISTORY:

Please list if you consume any of the following along with amount:

□ Tobacco _____
□ Caffeine _____
□ Alcoholic Beverages _____
□ Recreational Drugs_____

Marital Status: _____
Who do you live with: _____
Occupation: _____