Mountain Heart Medical
2000 S Thompson Street
Flagstaff, AZ 86001
Phone: 928 226-6400
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SLEEP MEDICINE HISTORY FORM

Name:_____ DOB:_____ Age:_____ Sex: M/F

Weight: _____ lbs Height:_____ ft _____in

Primary Care Provider: _____ Collar size (inches): _____

Please circle the appropriate response

SLEEP ROUTINE:

1. What TIME do you GO TO BED? _____
2. How long does it take for you to fall asleep? _____
   What occurs during that time?_____
3. Do you frequently wake up in the middle of the night? YES/NO
   a. If YES, how many times? _____
   b. What is the reason for waking up during the night? _____
   c. How long does it take you to return to sleep? _____
4. What TIME do you WAKE UP in the morning? _____
5. Do you feel REFRESHED UPON WAKING UP? YES/NO
6. Do you take any
   a. Scheduled/Planned Naps YES/NO When_____ How Long_____
   b. Unscheduled/Unplanned Naps? YES/NO ___ When driving
      ___ When inactive
      ___ In conversations
   c. IF YES, Do you feel refreshed after the nap? YES/NO
7. Any change in sleep schedule on your DAYS OFF? _____
8. Have you recently had any change in your WEIGHT in the PAST 3 YEARS? GAINED/LOST How much? _____

SLEEP APNEA SYMPTOMS:

9. Has anyone told you that you SNORE? YES/NO
   a. If YES, How LOUD? MILD/ MODERATE/ LOUD/ VERY LOUD
   Has anyone seen you STOP BREATHING or have pauses in breathing when you sleep? YES/NO
10. Do you wake-up from sleep with a CHOKING/GAGGING sensation? YES/NO
11. Has anyone told you that you MAKE SNORTING/GASPING noises in sleep? YES/NO
12. Do you wake up with a DRY MOUTH? YES/NO
13. Do you wake up with a HEADACHE? YES/NO
14. Do you DROOL on the pillow? YES/NO
15. Do you feel TIRED during the day? NO/ Mild/ Moderate/ Severe

SLEEP MEDICINE HISTORY FORM

RESTLESS LEGS:

16. Do you have UNCOMFORTABLE SENSATIONS in your legs before bedtime? YES/NO
17. If YES, please describe them? _____
18. Do you have any of the following during sleep?
    a. SLEEPWALKING YES/NO
    b. SLEEP TALKING YES/NO
    c. FREQUENT NIGHTMARES YES/NO
    d. ACTING OUT DREAMS YES/NO

SLEEP HYGIENE:

1. Do you do any of these activities in your bed/bedroom?
    a. WATCH TV YES/NO
    b. EAT YES/NO
    c. READ YES/NO
2. Do you drink coffee/caffeinated beverages? Never/Occasional/Moderate
3. SMOKING Never/Former/Current
4. Do you drink ALCOHOL? Never/Occasional/Moderate
5. Do you use illicit drugs? YES/NO Type_____

MISCELLANEOUS:

1. When FALLING ASLEEP or WAKING UP
    a. Do you ever SEE or HEAR things? YES/NO
    If YES, DESCRIBE _____
    b. Do you ever FEEL PARALYZED? YES/NO
2. Do you ever feel SUDDEN MUSCLE WEAKNESS when you are laughing? YES/NO

DRUG ALLERGIES: Check box if no known allergies to any medications ❑.

a. Drug name _____ - What Reaction?_____
b. Drug name _____ - What Reaction?_____
c. Drug name _____ - What Reaction?_____

FAMILY HISTORY:

1. Does anyone in your family have sleep apnea, insomnia, restless legs, or narcolepsy? YES/NO _____
    a. If YES, who? _____

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CURRENT MEDICATIONS: Please list all of your current medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you ever had a SLEEP STUDY before? NO/YES where?_____

PAST MEDICAL HISTORY

❏ Hypertension (high blood pressure)
❏ Heart attack
❏ Cardiac arrhythmias
❏ Atrial fibrilation
❏ Lung problems / COPD / Asthma
❏ Parkinson's disease
❏ Arthritis
❏ Depression / anxiety / bipolar
❏ Nasal allergies / nasal congestion
❏ Congestive heart failure
❏ Stroke / TIA
❏ Pulmonary hypertension
❏ Anemia / iron deficiency
❏ Seizures
❏ Autoimmune disease
❏ End stage kidney disease / dialysis
❏ Thyroid disease
❏ Diabetes
❏ Heartburn / reflux
❏ Fibromyalgia
❏ Menopause
❏ Cancer
❏ Broken nose
❏ Head injury
❏ Chronic Pain (reason)_____

Other:_____

SURGERIES:

Please list all your surgeries

_____

_____

_____

REVIEW OF SYSTEMS: Check the symptoms you frequently experience:

Const: ❏ Fever ❏ Feeling poorly ❏ Feeling tired ❏ Chills

ENT: ❏ Ear pain ❏ Frequent nosebleeds ❏ Sore throat ❏ Hearing loss ❏ Nasal discharge ❏ Hoarseness lasting more than 2 weeks ❏ Nasal congestion

Heart: ❏ Passing out ❏ Chest pain, tightness or pressure ❏ Palpitations ❏ Swelling of feet/ ankles

Resp: ❏ Shortness of breath ❏ Frequent cough for more than 2 weeks ❏ Wheezing

GI: ❏ Abdominal pain ❏ Difficulty swallowing/ food "sticking" ❏ Frequent heartburn/ indigestion ❏ Constipation ❏ Diarrhea ❏ Nausea ❏ Vomitting

MSK: ❏ Joint pain ❏ Joint swelling ❏ Joint stiffness ❏ Limb pain ❏ Limb swelling ❏ Muscle pain ❏ Back pain

Neuro: ❏ Frequent headaches ❏ Seizures ❏ Numbness/tingling ❏ Weakness ❏ Ringing in ear(s)

Behav: ❏ Anxiety ❏ Change in personality ❏ Sleep disturbance ❏ Depression

Hema: ❏ Swollen glands ❏ Easy bleeding ❏ Easy bruising

GU: ❏ Frequent need to urinate at night ❏ Incontinence ❏Sexual dysfunction/loss of libido

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Sleep Facility

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EPWORTH SLEEPINESS SCALE FORM

NAME_____ DOB_____ DATE_____

The test is a list of eight situations in which you rate your tendency to become Sleepy

Instructions: Be as truthful as possible.
Write down the number corresponding to your choice in the right hand column. Total your score below.

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

SITUATION	SCORE
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g., a theater or a 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 = _____