First Name: **Last Name:**

Date of Birth:

Gender: Male ☐ Female ☐

Marital Status: Never Married ☐ Married ☐ Divorced ☐ Widowed ☐

Primary Physician:
Phone Number:

Main Sleep Concern / Problem: (Check all that apply)

Sleepiness / Feeling tired ☐
Breathing stops while sleeping ☐
Difficulty staying asleep ☐
Difficulty falling asleep ☐
Bed partner asking you to seek help ☐
Other Reason ☐

How long have you experienced sleep problems?

Please describe any past professional evaluations or treatments for your sleep problems. (Please include what was and was not helpful)

Have you had a sleep study before? (If so, please provide where and when it was performed)

Please check any of the following activities you do in bed?

Read ☐ Watch TV ☐ Eat ☐ Talk on the phone ☐ Listen to music ☐
Argue ☐ Worry ☐ Watch the clock ☐ Use a device ☐

Does your bed feel comfortable to you? Yes ☐ No ☐

Is your bedroom comfortable, dark, and quiet? Yes ☐ No ☐

How many pillows do you sleep with under your head?

What is your occupation?

Who is your employer?

Do you work nights or shift work? Yes ☐ No ☐

What type of exercise do you do? (if any)

How often do you exercise?

Sleep Symptoms

When trying to sleep how often do you experience the following:

	Daily	Weekly	Monthly	Rarely	Never
Difficulty *falling* asleep?	☐	☐	☐	☐	☐
Trouble *staying* asleep?	☐	☐	☐	☐	☐
Repeated awakenings?	☐	☐	☐	☐	☐
Waking up *too early?*	☐	☐	☐	☐	☐
Snoring or trouble breathing?	☐	☐	☐	☐	☐
Choking or gasping for air?	☐	☐	☐	☐	☐
Morning headaches?	☐	☐	☐	☐	☐
Dry mouth?	☐	☐	☐	☐	☐
Have others said you stop breathing at night?	☐	☐	☐	☐	☐
Irresistible desire to move legs?	☐	☐	☐	☐	☐
Kept awake because of bed partner?	☐	☐	☐	☐	☐

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you:

Sitting and reading

- ☐ Would never doze
- ☐ Slight chance of dozing
- ☐ Moderate chance of dozing
- ☐ High chance of dozing

Watching TV

- ☐ Would never doze
- ☐ Slight chance of dozing
- ☐ Moderate chance of dozing
- ☐ High chance of dozing

Sitting inactive in a public place (theater, meeting, etc.)

- ☐ Would never doze
- ☐ Slight chance of dozing
- ☐ Moderate chance of dozing
- ☐ High chance of dozing

As a passenger in a car for an hour without a break

- ☐ Would never doze
- ☐ Slight chance of dozing
- ☐ Moderate chance of dozing
- ☐ High chance of dozing

Lying down to rest in the afternoon when circumstances permit

- ☐ Would never doze
- ☐ Slight chance of dozing
- ☐ Moderate chance of dozing
- ☐ High chance of dozing

Sitting and talking to someone

- ☐ Would never doze
- ☐ Slight chance of dozing
- ☐ Moderate chance of dozing
- ☐ High chance of dozing

Sitting quietly after lunch *without* alcohol

- ☐ Would never doze
- ☐ Slight chance of dozing
- ☐ Moderate chance of dozing
- ☐ High chance of dozing

In a car, while stopped for a few minutes in traffic

- ☐ Would never doze
- ☐ Slight chance of dozing
- ☐ Moderate chance of dozing
- ☐ High chance of dozing

Medical Review of Systems

Headaches ☐
Vision problems ☐
Nasal congestion ☐
Difficulty swallowing ☐
Chest pain ☐
Heart palpitations ☐
Wheezing ☐
Erectile dysfunction ☐

Shortness of breath ☐
Abdomen discomfort ☐
Diarrhea ☐
Constipation ☐
Bloody stools ☐
Urinary frequency ☐
Incontinence ☐

Muscle pain ☐
Joint pain ☐
Skin rash ☐
Feeling depressed ☐
Feeling anxious ☐
Heart burn ☐
Coughing ☐

General Medical History

Do you currently have or have you ever been diagnosed with: (check all that apply)

High blood pressure ☐
Heart disease ☐
Heart attack ☐
Kidney disease ☐
Neurologic disease ☐
Stroke ☐
Anxiety / Panic disorder ☐

Elevated cholesterol ☐
Lung disease ☐
Heart arrhythmia ☐
Head trauma / Concussion ☐
Seizure disorder ☐
Thyroid disease ☐
Fibromyalgia ☐
Drug abuse / addiction ☐

Diabetes ☐
Liver disease ☐
Stomach reflux (GERD) ☐
Immune disorder ☐
Arthritis ☐
Depression ☐
Alcoholism ☐

Other Medical Conditions:

Allergies to Medications:

Medications:

Medication Name	Dosage	Frequency

Many commonly used substances can affect sleep. Please describe your use of the following over the last month.

If you drink **Caffeinated** beverages (including coffee, tea, sodas etc.) please list your daily consumption.

If you drink **Alcoholic** beverages (including wine, beer, liquor) please list your daily consumption.

If you use **Tobacco** products (include cigarettes, cigars, snuff, chew, etc) list your daily use.

Family Medical History

Please list relatives (parents, siblings, children etc.) who snore, or have sleep apnea:

Please list family medical history such as heart disease, stroke, diabetes, cancer: