130 Preston Executive Drive Cary, NC 27513 Ph(919)462-8081 Fax(919)462-8082 www.parkwaysleep.com



# Patient History

***Please fill out in dark BLACK INK only.**

## General Information

Name ____________________________________________ Sex: ☐ Male ☐ Female Date________________

Date of Birth _________________________ Height ____________ Weight ____________ Neck Size_______________

Primary Physician ______________________________ Referring Physician _______________________________

Current occupation: _____________________________

## Sleep History

1. Please describe your sleep disturbance: ________________________________________________________
___________________________________________________________________________________

2. How long have you had this problem?
___________________________________________________________________________________

3. Are you currently on CPAP? ☐ Yes ☐ No

4. Has anyone else told you that you snore? ☐ Yes ☐ No
If yes for how many years?______________________________________________________________

5. Has anyone ever told you that you stop breathing during sleep? ☐ Yes ☐ No
If Yes, how long ago________________________________________________________________

6. Do you suddenly wake up gasping for breath or are you short of breath? ☐ Yes ☐ No

7. Sleep times:

| | Weekday | Weekend |
|---|---|---|
| Normal bedtime | | |
| Normal wakeup time | | |

8. How many hours of sleep do you get: On an average night ____________ On a bad night ________________

9. How long does it take to fall asleep? On an average night ____________ On a bad night ________________

10. How many times do you wake up during the night? On an average night ________ On a bad night ________________
    - What wakes you up during the night?_______________________________________________
    - How long does it take to fall back asleep?___________________________________________

11. What do you do when you can't fall asleep?
___________________________________________________________________________________

12. Do you wake up confused and/or wander during the night? ☐ Yes ☐ No
13. Are you unable to move when falling asleep or immediately upon waking? ☐ Yes ☐ No
14. Have episodes of sudden muscular weakness (paralysis or inability to move) when laughing, angry or emotional situations? ☐ Yes ☐ No
15. Have vivid or life-like visual images while falling asleep or upon wakening? ☐ Yes ☐ No
16. Loss of bladder or bowel control during sleep? ☐ Yes ☐ No
17. Do you have repetitive movements of arms or legs during sleep? ☐ Yes ☐ No
18. Do you have any difficulty with your sexual functioning? ☐ Yes ☐ No
19. Have you initiated or participated in sexual activity during sleep? ☐ Yes ☐ No
20. Do you grind your teeth at night? ☐ Yes ☐ No
21. Do you walk in your sleep? ☐ Yes ☐ No
22. Do you notice that your legs jerk or twitch during the night? ☐ Yes ☐ No
23. Do you see or hear things if you wake up during the night when there is nobody around you? ☐ Yes ☐ No
24. Do you suffer with pain during the night? ☐ Yes ☐ No
25. Do you wake up due to acid reflux during the night? ☐ Yes ☐ No

## Daytime Functioning

1. Are you sleepy or tired during the day? ☐ Yes ☐ No
   If yes, How many years:______________________________
2. Is sleepiness or fatigue affecting your: ☐ mood ☐ memory ☐concentration
3. Have you ever had car accidents, or near accidents caused by your sleepiness ? ☐ Yes ☐ No
4. Do you fall asleep without meaning to during the day? ☐ Yes ☐ No
5. How many naps do you take during the average week? _________ per week. How long is your nap? ___________________
6. At what time of the day do you feel the most fatigued/sleepy? ______________________________

## Restless Leg Syndrome Screen

1. Do you have an urge to move your legs, accompanied or caused by uncomfortable leg sensations? ☐ Yes ☐ No
2. Do you get relief with movement, partial or total relief, by walking or stretching? ☐ Yes ☐ No
3. Is there worsening of symptoms at rest or inactivity, such as when lying or sitting? ☐ Yes ☐ No
4. Is there worsening of symptoms in the evening or at night? ☐ Yes ☐ No

**Any other Sleep related issue?**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

# Sleep Hygiene

1. Are you a second shift or a night shift worker? ☐ Yes ☐ No
   If yes, please describe:
   ______________________________________________________________________________________

2. Do you exercise? ☐ Yes ☐ No
   If yes, describe your routine
   ______________________________________________________________________________________

3. Do you take a hot bath or shower within 2 hours of bedtime? ☐ Yes ☐ No

4. Do you eat within 3 hours of bedtime? ☐ Yes ☐ No

5. What activities do you engage in while in the bedroom setting? (i.e. reading, TV, work)?
   ______________________________________________________________________________________
   ______________________________________________________________________________________

6. Are there any problems that interfere with your sleep (such as noise, temperature, pain, bed partner)? ☐ Yes ☐ No

7. Do you have problems with thoughts running through your mind at bedtime? ☐ Yes ☐ No
   If yes, please describe:_______________________________________________________________________
   ______________________________________________________________________________________

# Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?

This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to estimate 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:

Sitting and reading _____________

Watching TV _____________

Sitting inactive in a public place (i.e. theatre 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 with someone _____________

Sitting quietly after lunch without alcohol _____________

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

**Total:** ______________

# Medical History

**Please check if YOU have *ever* had any of the following conditions:**

| | | | | |
|---|---|---|---|---|
| ☐ Diabetes | ☐Hyper/hypo thyroidism | ☐Arthritis | ☐ Dementia | ☐Low back pain |
| ☐ Asthma | ☐Epilepsy or seizures | ☐Migraine headaches | ☐ Atrial fibrillation | ☐Fibromyalgia |
| ☐ Multiple sclerosis | ☐ Hallucinations or delusions | ☐GERD or reflux disease | ☐Parkinson's Disease | ☐CHF |
| ☐ Cancer | ☐ Problems with alcohol/drugs | ☐Chronic pain | ☐Heart attack | ☐Neuropathy |
| ☐Chronic sinus disease | ☐ Hiatal hernia | ☐Stroke | ☐COPD | ☐Ulcers |
| ☐High blood pressure | ☐High cholesterol | ☐Other (please describe) | | |

________________________________________________________________________________

________________________________________________________________________________

# Surgical History

List any previous surgeries and dates:

1. ______________________________________ 2. ______________________________________

3.______________________________________4.______________________________________

5.______________________________________6.______________________________________

# Psychiatric History

☐ Anxiety/panic attacks ☐ Depression ☐ Other (Please describe.)

________________________________________________________________________________

________________________________________________________________________________

# Weight History

1. My lowest weight was: ________when I was _______years of age.
2. My highest weight was: ________when I was _______years of age.
3. My weight last year was:____________5 years ago:______________10 years:_________In High School:___________
4. Have your ever tried any weight loss program?______________________________________

# Family Medical History

1. List any pertinent FAMILY medical problems (particularly sleep problems):

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

2. Does anyone in your family have sleep problems? ☐ Yes ☐ No

If Yes, please describe:

________________________________________________________________________________

________________________________________________________________________________

3. Does anyone in your family snore? ☐ Yes ☐ No

If "Yes," please list which family member:______________________________________

# Social History

Smoking Status (please select one of the following):

☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Former Smoker ☐ Never Smoked

How much of the following do you consume during the average day?

| Item | Daily Usage | How Long? |
|---|---|---|
| Alcohol | | |
| Coffee | | |
| Tea (with caffeine) | | |
| Soft Drinks (with caffeine) | | |
| Cigarettes | | |
| Other Tobacco: | | |

Do you or have you ever used recreational drugs: ___________________________________________________________________

# Medications

| Medication Name | Dose | Frequency | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Please list all PREVIOUS sleeping medications:**

| Medication Name | Dose | Frequency | Reason for Stopping |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Medication Allergies:**

| Medication Name | Describe Allergy or Reaction |
|---|---|
| | |
| | |
| | |
| | |

# Bed Partner Survey:

***(To be filled out by someone who has watched you while sleeping)***

1. How long have you been together?___________________________________________________________________________

2. Does he/she snore?____ ☐ Yes ☐ No
   - Is the snoring: ☐Mild ☐Moderate ☐Loud
   - Is the snoring: ☐Periodic ☐Continuous
   - Is the snoring louder in any one position?_____________________________________________________________

3. Does he/she stop breathing during sleep? ☐ Yes ☐ No

4. Does he/she choke or gasp for air during sleep? ☐ Yes ☐ No

5. Does he/she act out dreams? ☐ Yes ☐ No

6. Does he/she wake up screaming? ☐ Yes ☐ No

7. Does he/she perform repetitive or seemingly purposeless acts during the night? ☐ Yes ☐ No

8. Does he/she have trouble falling asleep or staying asleep? ☐ Yes ☐ No

9. Do you notice that their legs jerk or twitch during the night? ☐ Yes ☐ No

10. Is he/she dozing off or napping during the day? ☐ Yes ☐ No

11. Have you noticed any recent changes is his/her: ☐ Mood ☐ Memory ☐ Concentration_______________

12. Please summarize your observations or concerns about his/her sleep issues:

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________