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Patient Information

Last Name	First	MI	Age	Birth Date	Sex
Address	City	State	Zip Code		
Social Security Number	Home Phone	Cell Phone	Marital Status		
Driver's License Number	Family Physician	Phone			
Chief Complaint					
Occupation	Hours Worked?	If Retired, When?			
Patient Employer Name	Employer Address				
City, State	Zip	Employer Phone			
Referring Physician	Phone				

Emergency Contact

Last Name	First	MI	Relationship to Patient
Address	City	State	Zip Code
Home Phone	Secondary Phone		

Insurance Information - Primary:

Company Name	Identification Number	
Policy Holder's Name/ Date of Birth	Social Security Number	Relationship to Patient

Secondary:

Company Name	Identification Number	
Policy Holder's Name/ Date of Birth	Social Security Number	Relationship to Patient

Third:

Company Name	Identification Number	
Policy Holder's Name/ Date of Birth	Social Security Number	Relationship to Patient

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Name: ______________________________ **Date of Birth:** _________ **Date:** _________

Who referred you? ____________________________________

Who is your primary care physician? _____________________________

Which physicians should our office send your sleep center records? __________________

Describe your sleep problems: ____

____

____

Duration? ________ Have you ever been to a sleep center before? Yes____ No____

If so, where and when? ____

What treatment was recommended? ____

DROWSINESS / SLEEPINESS

Are you frequently fatigued or drowsy during the day?	Yes____	No___
Have you had any accidents or near traffic accidents due to sleepiness?	Yes____	No___
Have you had any accidents at work due to sleepiness?	Yes____	No___

BODY POSITION

Do you spend most of the night sleeping on your back? Side? Stomach?

SNORING / APNEA

Has anyone told you that you snore loudly?	Yes____	No___
Do you snore in all sleeping positions (on your back and sides)?	Yes____	No___
Do you snore almost continuously all night, every night?	Yes____	No___
Have you awakened with a dry mouth?	Yes____	No___
Has anyone told you that you quit breathing at night?	Yes____	No___
Have you ever awakened gasping for breath?	Yes____	No___
Do you have excessive sweating at night?	Yes____	No___
Do you ever wake at night with coughing, choking, or respiratory discomfort?	Yes____	No___
Do you have morning headaches? Yes____ No___ Morning sore throat?	Yes____	No___

REFLUX

Do you often wake with a sour taste/burning sensation in your chest/throat?	Yes____	No___

NARCOLEPSY

Do you have sudden episodes of sleepiness during the day?	Yes____	No___
Have you ever felt paralyzed while going to sleep or waking up from sleep?	Yes____	No___
Have you ever experienced sudden physical weakness during strong emotions? (such as your mouth dropping open or legs going limp, during laughter or anger)	Yes____	No___
Have you ever seen or heard things that aren't real (hallucinations) when you are going to or awakening from sleep?	Yes____	No___

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CHILDHOOD Did you have childhood sleep problems of any type? Yes____ No___
If yes, describe them. ____

RLS/PLMS Do your legs get tingling sensations/pain and you just have to move them? Yes____ No___
Do you frequently kick or jerk your legs at night? Yes____ No___

INSOMNIA
Do you have trouble going to sleep at your bedtime? Yes____ No___
Do you have difficulty staying asleep? Yes____ No___
Do you have pain that bothers you at night? Yes____ No___

PARASOMNIAS DO YOU *(THE PATIENT)* DO ANY OF THE FOLLOWING?
Sleep walk? Yes____ No___ Wet the bed at night? Yes____ No___
Have frequent nightmares? Yes____ No___ Talk in your sleep? Yes____ No___
Ever wake up screaming? Yes____ No___ Falling out of bed? Yes____ No___
Grind your teeth in your sleep or wake up with jaw pain? Yes____ No___

WORK HISTORY:

ARE YOU: Employed? Yes____ No___ A homemaker? Yes____ No___ Retired? Yes____ No___
What type of work do you do? ________________
ARE YOU: A student? Yes____ No___ Highest level of education? ______
Disabled? Yes____ No___ Due to what? ______________________
WORK SCHEDULE:
When does your usual work shift start? _____ AM or PM
When does your usual work shift end? _____ AM or PM
Hours worked per week? _____ Do you do shift work? Yes____ No___

SLEEP SCHEDULE:

	WEEKDAY	WEEKEND		WEEKDAY	WEEKEND
Time you go to bed	_______	_______	Time you get up	_______	_______

How long does it take you to fall asleep? __________ hours/minutes
How often do you wake during the night? __________
How many hours do you sleep each night? Average _____ Least _____ Most _____

**** THESE NEXT 10 QUESTIONS ARE TO BE COMPLETED BY THE BED PARTNER ****			
Does the patient:			
Snore heavily?	Yes____ No___	Stop breathing during the night?	Yes____ No___
Snore continuously?	Yes____ No___	Have seizures during the night?	Yes____ No___
Snore every night?	Yes____ No___	Talk in their sleep?	Yes____ No___
Sweat during the night?	Yes____ No___	Kick and jerk frequently?	Yes____ No___
Sleep walk?	Yes____ No___		
Do you have additional comments?	____________________________________		

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How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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. 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	**Chance of dozing** (write 0, 1, 2, or 3)
Sitting and reading	______
Watching television	______
Sitting, inactive in a public place such as a 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 to someone	______
Sitting quietly after a lunch without alcohol	______
In a car, while stopped for a few minutes in traffic	______
TOTAL SCORE: (Add All Responses)	______

OTHER ILLNESSES: **Circle those that apply.**

Diabetes	High Blood Pressure	Emphysema/COPD	High Cholesterol
Coronary Artery Disease	Irregular Heart Beat	Stroke	Gastro-esophageal Reflux
Depression	Anxiety	Thyroid Disease	Kidney Disease
Allergies	Cancer	Migraines	Glaucoma

Other ______________________________

SURGICAL HISTORY: **Circle those that apply.**

SINUS SURGERY	Cardiac Bypass	Nasal Surgery	Hysterectomy/OO-phorectomy
Jaw Surgery / UPPP / Tonsils	Other______________		Other ______________
Other ______________	Other______________		Other______________

DO YOU USE OXYGEN? Yes_____ No_____   _____ Liters/minute

_____Continuous   _____ During Sleep   _____ With Exertion   _____As Needed

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List Your Medications. Include over the counter medications, vitamins, and supplements.

NAME	SIZE(MG)	HOW YOU TAKE IT (Ex. 3 TIMES A DAY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
Medication Allergies:		

HEALTH HABITS:

Do you smoke? Yes____ No___ If yes, how long? __________ How many packs/day? ________

Cigars/day? _____ If ex-smoker, how long did you smoke? _______ When did you quit? _______

Do you use smokeless tobacco? Yes____ No___ How much per day? ___________________________

ALCOHOL/DRUGS Do you ever drink alcohol? Yes____ No___

If yes, how much and what kind? ____

Have you ever had a problem with drinking too much alcohol? Yes____ No___

Use street drugs? Yes____ No___ Have a past history of substance abuse? Yes____ No___

CAFFEINE Do you drink coffee? Yes____ No___, Regular__ or Decaffeinated__, ____cups/day

Do you drink soft drinks with caffeine Yes____ No___ How many/day? _____

Do you drink tea with caffeine Yes____ No___ How many cups/glasses/day? _____

MEALS How many meals do you eat daily? _____

EXERCISE Do you exercise regularly? Yes____ No___ Frequency _____ Minutes _____

Type of exercise: ____

FAMILY HISTORY: Circle the Condition and then List Affected Family Members

CONDITION	AFFECTED FAMILY MEMBER	CONDITION	AFFECTED FAMILY MEMBER
Diabetes	____________________	**Narcolepsy**	____________________
Heart Disease	____________________	**Daytime sleepiness**	____________________
High Blood Pressure	____________________	**Depression**	____________________
Stroke	____________________	**Anxiety**	____________________
Obesity	____________________	**Sleep Apnea**	____________________
Other (describe):	____________________	**Other (describe):**	____________________

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Circle any symptoms that you have.

REVIEW OF SYSTEMS/SYMPTOMS

Eyes	Blurry vision	Loss of Vision	Double vision	Dry Eyes	
Ears,Nose & Throat	Hearing Loss	Ringing	Ear Pain	Sore Throat	Dry Mouth
Heart	Chest Pain	Heaviness	Racing or Pounding		
Pulmonary	Short of Breath	Wheezing	Cough	Coughing up blood	Phlegm
Stomach & GI Tract	Dry Mouth Stomach Pain	Trouble Swallowing Diarrhea	Stools Black as Tar Bright blood in Stools	Constipation Nausea	Heart Burn Vomiting
Genitourinary	Urine with Cough Sexual Problems	Incontinence Dribbling Urine	Trouble Emptying the Bladder	Blood in Urine Burning	Frequent Urination
Muscle/Skeletal	Back Pain Twitching Muscles	Neck Pain Arm or Leg Pain	Sore Muscles Stiffness	Swollen Joints	Cramps
Skin	Itching	Rash	Blisters	Peeling	Dry Skin
Neurologic	Weakness Headache	Imbalance Jerking/Shaking Tremor	Numbness/Tingling Forgetfulness	In coordination Light Headedness	Dizziness Slurred Speech
Psychological	Personality Change Irritable	Loss of Interest Depressed	Angry Crying spells	Sad Nervous	Withdrawn Suicidal Thoughts
Endocrine	Frequent Thirst	Always cold	Always Hot		
Hematologic	Bruising	Bleeding Easily	Swollen Glands		
Allergy	Burning Eyes	Runny Nose	Nasal Congestion		
Constitutional	Fatigue	Night Sweats			
Weight	Weight change in past 5 years:		Gained ____#	Lost ____#	

Is there anything else that you feel that your sleep physician should know?

____

____

Who completed the questionnaire? ______________________________

By yourself ___ or with help ___? If help, from whom? ____________________

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Beck Depression Inventory

Instructions: These questions consist of seven groups of statements. Read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past 2 weeks, including today**. Circle the number beside the statement you have picked. If several statements in one group seem to apply equally well, choose the statement with the highest number beside it.

1	Sadness	I do not feel sad……………………………………..………………….....	0
		I feel sad much of the time…………………………………………..…	1
		I am so sad all the time……………………………………………..…..	2
		I am so sad or unhappy that I can't stand it…………………………..……	3
2	Pessimism	I am not discouraged about my future……………………………….…	0
		I feel more discouraged about my future than I used to be……………..	1
		I do not expect things to work out for me……………………………....	2
		I feel my future is hopeless and will only get worse…………………...	3
3	Past Failure	I do not feel like a failure……………………………………………....	0
		I have failed more than I should have……………………………….…	1
		As I look back, I see a lot of failures…………………………………..…	2
		I feel I am a total failure as a person……………………………...…..	3
4	Self-Dislike	I seem the same about myself as ever………………………………..…	0
		I have lost confidence in myself…………………………………….….	1
		I am disappointed in myself…………………………………….…..…..	2
		I dislike myself……………………………………………………….....	3
5	Self-Criticalness	I don't criticize or blame myself more than usual……………………..	0
		I am more critical of myself than I used to be………………………..…	1
		I criticize myself for all of my faults……………………………….…..	2
		I blame myself for everything bad that happens……………………..…	3
6	Suicidal Thoughts	I don't have any thoughts of killing myself………….....................	0
		I have thoughts of killing myself, but I would not carry them out……..	1
		I would like to kill myself……………………………………………	2
		I would kill myself if I had the chance………………….....................	3
7	Loss of Interest	I have not lost interest in other people or activities…………………….	0
		I am less interested in other people or things than before……………...	1
		I have lost most of my interest in other people or things......................	2
		It's hard to get interested in anything…………………………………..	3

Total Score ______

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Berlin *Questionnaire*

Complete the following:

1. Do you snore?

_____ Yes
_____ No
_____ Don't know

If you snore:
2. Your snoring is?

_____ Slightly louder than breathing
_____ As loud as talking
_____ Louder than talking
_____ Very loud. (Can be head in adjacent rooms)

3. How often do you snore?

_____ Nearly every day
_____ 3-4 times a week
_____ 1-2 times a week
_____ 1-2 times a month
_____ Never or nearly never

4. Has your snoring ever bothered other people?

_____ Yes
_____ No

5. Has anyone noticed that you quit breathing during your sleep?

_____ Nearly every day
_____ 3-4 times a week
_____ 1-2 times a week
_____ 1-2 times a month
_____ Never or nearly never

6. How often do you feel tired or fatigued after your sleep?

_____ Nearly every day
_____ 3-4 times a week
_____ 1-2 times a week
_____ 1-2 times a month
_____ Never or nearly never

7. During your wake time, do you feel tired, fatigued or not up to par?

_____ Nearly every day
_____ 3-4 times a week
_____ 1-2 times a week
_____ 1-2 times a month
_____ Never or nearly never

8. Have you ever nodded off or fallen asleep while driving a vehicle?

_____ Yes
_____ No

9. If yes, how often does it occur?

_____ Nearly every day
_____ 3-4 times a week
_____ 1-2 times a week
_____ 1-2 times a month
_____ Never or nearly never

10. Do you have high blood pressure?

_____ Yes
_____ No
_____ Don't know

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Driving Directions:

From I-40 West, take exit 378 (Cedar Bluff Rd). Take exit B to Executive Park Dr. Turn Left at the red light onto Executive Park Dr. Go straight through next red light (you will cross N. Cedar Bluff Rd) onto Park West Blvd. Get into the right lane and go straight. Parkwest Medical Center will be on the left.

From I-40 East, take exit 378 (Cedar Bluff Rd). Get in the left hand lane and turn left at the light. Go under I-40 and go to the second red light. Turn left onto Park West Blvd. Get into the right lane and go straight. Parkwest Medical Center will be on the left.

*Enter the hospital through the main entrance (where valet parking is).

If coming for clinic go to the hallway on the left and we are the third door on the left.

If coming for a sleep study go straight ahead to registration to be registered before coming to the department. .