ADULT (age ≥ 16) SLEEP MEDICINE HISTORY ***St Elizabeth Sleep Disorders Centers***

Name _____ Date of Birth _____ Date_____

Reason for my visit: _____

PLEASE COMPLETE ALL ITEMS ☑ ***CHECK IF TRUE***

- ☐ I have been **abnormally sleepy / tired** for _____ months
- ☐ I usually **do not feel rested** after sleep
- ☐ I tend to **fall asleep while driving** (accidents or near accidents)
- ☐ I tend to be **sleepy when** reading, watching TV, talking, riding in a car or eating
- ☐ **Sleepiness interferes** with my job, schoolwork, memory, social life or sexual interest
- ☐ I work as a **pilot, bus or truck driver** (regulated by FAA or DOT)

- ☐ I have had **prior treatment** for sleep apnea at _____
- ☐ Someone has **witnessed** (seen or heard) me stop breathing when I sleep
- ☐ I wake up **gasping, choking** or smothering for air
- ☐ I have loud, disruptive **snoring**
- ☐ Need to **go to the bathroom** _____ times per night
- ☐ My **close relative** (_____) **has sleep apnea**

- ☐ I have moderate or severe **lung disease**
- ☐ I have **pulmonary hypertension** (high blood pressure in the lungs)
- ☐ I have **congestive heart failure** and shortness of breath with regular activity or at rest
- ☐ I have an **uncontrolled heart rhythm disorder** (rapid, slow or irregular pulse)
- ☐ I have a **neurologic disease that affects my breathing**
- ☐ My **hypertension is difficult to control** (on 3 or more medicines)

- ☐ I tend to **kick or move my arms** a lot when I sleep (Periodic Limb Movements)
- ☐ My **close relative** (_____) **has narcolepsy**
- ☐ I get **sudden muscle weakness** when I laugh, get angry or am surprised (cataplexy)
- ☐ I have had **hallucinations** while falling asleep or waking up
- ☐ I have been **paralyzed** (can't move) while falling asleep or waking up
- ☐ I have had **violent or bizarre behavior** during sleep (REM behavior disorder)
- ☐ I may have had a **seizure while asleep**
- ☐ I get an irresistible **urge to move my legs or arms** due to crawling or tingling (RLS)

Sleep Habits	Bedtime	Up for the Day	Total Sleep / Day
Week days / Work days	_____am/pm	_____am/pm	_____hours
Week ends / Days off	_____am/pm	_____am/pm	_____hours

☐ I spend **time in my bedroom** awake
☐ I **watch TV or read in bed** before sleep
☐ If I can't sleep, I **stay in my bedroom**
☐ I usually **sleep in** on days off work
☐ I frequently **travel across time zones**
☐ I work **3rd shift** or **rotating shifts**

It takes me _____**minutes to fall asleep** **I wake up** _____ **times at night**

☐ I have had **trouble getting to sleep or staying asleep** for _____ months
☐ My **mind races** when I try to sleep
☐ I am a light, **restless** sleeper
☐ It is **difficult to go back to sleep**
☐ I use **sleeping pills** or **alcohol** to sleep
☐ I have **trouble sleeping** due to _____

Review of Systems

CONSTITUTIONAL:
☐ Gained weight (____ lb) in the past year

EAR NOSE THROAT:
☐ Frequent sinus congestion
☐ Frequent nosebleeds
☐ Other ear/nose/throat problem _____

CARDIOVASCULAR:
☐ High blood pressure
☐ Angina, heart attack, bypass, stent
☐ Other heart problem _____

RESPIRATORY:
☐ Asthma during sleep
☐ Home oxygen (____ L/min)
☐ Other lung disease _____

GASTROINTESTINAL:
☐ GERD (heartburn) at night
☐ Other stomach or intestine problem _____

GENITOURINARY:
☐ In or past menopause
☐ Wet the bed
☐ Other kidney / genital problem _____

MUSCULOSKELETAL:
☐ Bone or joint pain disturbs sleep
☐ Other bone / joint problem _____

NEUROLOGICAL:
☐ Stroke or TIA
☐ Muscle weakness
☐ Other nerve or muscle problem _____

PSYCHIATRIC:
☐ Chronic anxiety
☐ Depression
☐ Other emotional problem _____

ENDOCRINE:
☐ Thyroid underactive
☐ Diabetes
☐ Other hormone problem _____