

Helen Keller Hospital

NORTH ALABAMA SLEEP DISORDERS CENTER OF HELEN KELLER HOSPITAL

DATE _____ NAME _____ DOB _____

HOME PHONE _____ CELL/WORK _____ OCCUPATION _____

MALE OR FEMALE _____ MARITAL STATUS _____ Year of Last Physical Examination _____

REFERRING PHYSICIAN _____ PRIMARY CARE PHYSICIAN _____

What is your Height _____ Weight _____ Weight lost/gained in the past 5 years _____

HR _____ Resp _____ Blood Pressure _____ Neck Size in inches _____

Do you smoke? _____ Cigarettes, Cigars, Pipes? _____

Please explain reason for coming to sleep center _____

How long have you had this problem? _____

Medications and Allergies

Current Medications Prescription and Non Prescribed(use back of page if necessary)

Medication	Dose	Times Taken	Reason	How Long	Physician
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please list any allergies (medications, foods, latex, skin adhesives, environmental agents):



SLEEP CENTER SCAN

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HABITS

Alcohol	Y N	How much per day/ week _____
Antidepressants	Y N	How much per day/ week _____
Nerve medication	Y N	How much per day/week _____
Pain medication	Y N	How much per day/week _____
Antihistamines	Y N	much day/week _____
Caffeine drinks	Y N	How much per day/ week _____
Tobacco	Y N	How much per day/ week _____
Medication for sleep	Y N	How much per day/ week _____

Past Medical History

Have you had any health problems recently or in the past? _____

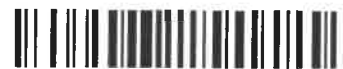
Have you been treated for:

Hypertension	Y N	How long? _____
Sinus/Allergies	Y N	How long? _____
Headaches	Y N	How long? _____
Anxiety or Depression	Y N	How long? _____
Cardiovascular Disease	Y N	How long? _____
Pain Management	Y N	How long? _____

Family History

Is there a family history of :

Narcolepsy	Y N	Relationship _____
Insomnia	Y N	Relationship _____
Sleep Apnea	Y N	Relationship _____
Restless Legs	Y N	Relationship _____
Other sleep disorders	Y N	Relationship _____



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Symptoms Review

Do you currently have problems with any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hearing impairment |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Lung Problems COPD/Asthma | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Hepatitis/jaundice |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression |
| <input type="checkbox"/> TIA/Light Stroke | <input type="checkbox"/> Severe Anxiety |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nasal Polyps/ nasal fracture |
| <input type="checkbox"/> Back or Joint Problems(arthritis) | <input type="checkbox"/> legs jerking at night |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Fainting/passing out |
| <input type="checkbox"/> Frequent heartburn/indigestion | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Hearing Loss or ringing in ears | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Vivid dreams |
| <input type="checkbox"/> Sleep paralysis | <input type="checkbox"/> Pain in joint s/bones |
| <input type="checkbox"/> Cough for more than 2-4weeks | <input type="checkbox"/> kidney stones |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Difficulty urination/incontinence |
| <input type="checkbox"/> Shortness of breath or wheezing | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Swelling in feet or ankles | <input type="checkbox"/> Urinating more than 2 times/night |
| <input type="checkbox"/> Chest Pain, pressure, or Heaviness | <input type="checkbox"/> Weight Loss of more than 5-10 pounds |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Unusual bruising or bleeding |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Sudden muscle weakness |
| <input type="checkbox"/> Sudden Loss of vision or strength/ inability to speak | <input type="checkbox"/> Chemical dependence |



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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 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

<u>SITUATION</u>	<u>CHANCE OF DOZING</u>
*Sitting and reading	_____
*Watching TV	_____
*Sitting, inactive in a public place (example: 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 with someone	_____
*Sitting quietly after a lunch without alcohol	_____
*In a car, while stopped for a few minutes in traffic	_____

20. What is your personal interpretation as to why you have your particular sleep/wake problem? Describe any other information pertinent to your sleep or wakefulness not previously described.



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