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 adhedsives, environmental agents):

_____

_____

_____

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SNORING

Do you snore? Y N If yes, how long _____

How does your family/ others describe your snoring?_____
Do you stop breathing in your sleep?_____
How often? _____ Occasionally/when tired/when drinking alcohol/all the time/ only on back

SLEEP PATTERNS

What are your normal work hours?_____ to _____ What days do you normally work?_____

Bed Time_____ How long does it take you to fall asleep_____How often do you waken?_____

If you take more than 10-15 minutes to fall asleep what keeps you awake?_____

How long does it take you to go back to sleep?_____

How many times do you use the bathroom at night?_____

What time do you awaken for the day?_____
How do you feel when you wake?_____
Does your schedule change on weekend/off days?_____

DAYTIME FUNCTION

How do you feel during the day?_____
Do you have problems staying awake at work?_____
Do you have problems staying awake while driving?_____
Do you nap during the day?_____ How long?_____

BEDROOM

Do you sleep with a bed partner ?	Y N
Do you listen to radio or TV to fall asleep?	Y N
Is your sleep disturbed by bed partner, pets, or children?	Y N

TREATMENT FOR SLEEP

Have you used any of the following treatments for sleep in the past?

Sleeping Pills	Y N
Antidepressants	Y N
Stimulants	Y N
CPAP or BIPAP	Y N
Surgery (sinus or throat)	Y N
Oral Device	Y N

Previous sleep studies Y N
When?_____
Where?_____

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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:

___Hypertension

___Heart Disease

___Epilepsy or seizures

___ Lung Problems COPD/Asthma

___Reflux

___Fibromyalgia

___Stroke

___ TIA/Light Stroke

___Sinus problems

___Back or Joint Problems(arthritis)

___Frequent headaches

___Frequent heartburn/indigestion

___Hearing Loss or ringing in ears

___Hiatal hernia

___Sleep paralysis

___Cough for more than 2-4weeks

___Coughing up blood

___Shortness of breath or wheezing

___Swelling in feet or ankles

___Chest Pain, pressure, or Heaviness

___Irregular heartbeat

___Difficulty Swallowing

___Hearing impairment

___Diabetes

___Cancer

___Alcoholism

___Thyroid Problem

___Hepatitis/jaundice

____Depression

___Severe Anxiety

___Nasal Polyps/ nasal fracture

___legs jerking at night

___Fainting/passing out

___Abdominal Pain

___Nosebleeds

___Vivid dreams

___Pain in joint s/bones

___kidney stones

___Difficulty urination/incontinence

___Blood in urine

___Urinating more than 2 times/night

___Weight Loss of more than 5-10 pounds

___Unusual bruising or bleeding

___Sudden muscle weakness

___Sudden Loss of vision or strength/ inability to speak

___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

SITUATION	CHANCE OF DOZING
*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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