Sleep History Sleep Center Referral, Pulmonary Associates (Template Sx.Sleep.OSA.New, ver 1.1)

Name: _____ **DOB:** _____ **Date:** _____

What symptoms or concerns prompted Dr. _____ to order a sleep evaluation?

_____

- **Please check any sleep symptoms that apply:**

☐ snoring ☐ stop breathing ☐ choke/gag arousals ☐ night time sweating

☐ dry mouth in AM ☐ headache In AM ☐ frequent arousals ☐ night time urination

☐ restless legs ☐ leg or body jerks ☐ leg cramps ☐ Other _____

- **Do you have trouble:** ☐ initiating sleep ☐ maintaining sleep ☐ both ☐ neither
- **In general, how long have you had sleep problems?** _____
- **How would you describe the symptoms:** ☐ mild ☐ moderate ☐ severe
- **Check any of the following daytime symptoms that apply:**

☐ sleepiness ☐ fatigue ☐ tiredness ☐ memory problems ☐ concentration problems

☐ irritability ☐ depression ☐ anxiety ☐ Other _____

- **What has your bed partner noticed or complained about?**

☐ no bed partner ☐ nothing of concern ☐ snoring ☐ stopping breathing ☐ jerking

☐ restless sleep ☐ sleep talking ☐ sleep walking ☐ acting out dreams

☐ Other _____

- **Have you ever:**

☐ fallen asleep while driving ☐ had a motor vehicle wreck due to sleepiness

☐ had trouble staying awake while driving ☐ none of the above

- **Check any medicines that you take for sleep:**

☐ Ambien/zolpidem ☐ Lunesta ☐ Restoril ☐ Trazadone ☐ Elavil ☐ Melatonin

☐ Doxepin ☐ Klonipin ☐ OTC sleep aids ☐ Other _____

- **Please rate your chance of falling asleep in the following situations:**
(Use this scale: 0 = never, 1 = slight chance, 2 = moderate chance, 3 = high chance)

Sitting or reading ____	Watching TV ____
Sitting inactive in public ____	Passenger in car for 1 hour ____
Lying down to rest in afternoon ____	Sitting and talking to someone ____
Sitting quietly after lunch ____	Driving, stopped in traffic ____

Total Score: ____0____

IMPORTANT: Driving while sleepy is dangerous. Many people have died or killed others after falling asleep while driving. If you are having problems staying awake while driving please let us know, and DO NOT DRIVE WHILE SLEEPY. Please initial after reading: _____

OFFICE USE ONLY:

MR#: _____

HPI:

PE:

Gen-

MP-1 2 3 4

Den· Y N

Neck-

CV- M G

Chest-

Abd-

Ext-

Ass:

Plan:

Review of Systems Pulmonary Associates (Template Sx.Pulm.ROS)

Please check any of the following symptoms which apply to you:

- **CONSTITUTIONAL**

  ☐ Fever ☐ Chills ☐ Sweats ☐ Weight Gain ☐ Weight loss

- **EYES**

  ☐ Eye pain ☐ Double Vision ☐ Blurred vision

- **HENT**

  ☐ Headaches ☐ Post nasal drip ☐ Nasal Congestion ☐ Nasal discharge

- **CARDIOVASCULAR**

  ☐ Chest pain ☐ Irregular heart beat ☐ Swelling ☐ Passing out

- **RESPIRATORY**

  ☐ Shortness of breath ☐ Wheezing ☐ Cough ☐ Sputum production

  ☐ Hoarseness ☐ Coughing up blood ☐ TB Exposure ☐ Chest wall pain

- **GASTROINTESTINAL**

  ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Reflux

  ☐ Blood in stools ☐ Jaundice ☐ Abdominal pain

- **GENITOURINARY**

  ☐ Frequent urination ☐ Night time urination ☐ Blood in urine

- **SKIN**

  ☐ Rash ☐ Itching ☐ Skin lesion

- **NEUROLOGIC**

  ☐ Weakness ☐ Seizures ☐ Altered mental status

- **MUSKULOSKELETAL**

  ☐ Joint pain ☐ Back Pain ☐ Joint swelling

- **SLEEP**

  ☐ Snoring ☐ Insomnia ☐ Daytime sleepiness

- **PSYCHIATRIC**

  ☐ Anxiety ☐ Depression ☐ Psychosis

- **ALLERGIC-IMMUNOLOGIC**

  ☐ Sinus allergies ☐ Eczema ☐ Food allergies

Sleep History

Sleep Symptoms

Please type the appropriate rating using the following scale:

1 = never, **2** = rarely, **3** = sometimes, **4** = frequently, **5** = constantly

Sleepiness:

1 2 3 4 5 ___ Fall asleep watching TV
1 2 3 4 5 ___ Take long naps
1 2 3 4 5 ___ Have trouble at work due to sleepiness
1 2 3 4 5 ___ Fall asleep in public
1 2 3 4 5 ___ Fall asleep driving

Leg symptoms:

1 2 3 4 5 ___ Have restless legs which inhibit sleep
1 2 3 4 5 ___ Have leg cramps during sleep
1 2 3 4 5 ___ Have uncomfortable sensations in your legs relieved with movement
1 2 3 4 5 ___ Move legs frequently while sleeping

Insomnia:

1 2 3 4 5 ___ Can't fall asleep in 15 minutes
1 2 3 4 5 ___ Wake up frequently
1 2 3 4 5 ___ Can't go back to sleep once awakened
1 2 3 4 5 ___ Have racing thoughts while trying to sleep
1 2 3 4 5 ___ Worry about daytime problems while trying to sleep
1 2 3 4 5 ___ Fell depressed
1 2 3 4 5 ___ Have lost interest in fun activities
1 2 3 4 5 ___ Feel guilty or inadequate
1 2 3 4 5 ___ Feel anxious
1 2 3 4 5 ___ Frustrated by inability to fall asleep
1 2 3 4 5 ___ Wake up one or two hours early
1 2 3 4 5 ___ Watch the clock at night

Snoring and Breathing:

1 2 3 4 5 ___ Have been told you snore
1 2 3 4 5 ___ Stop breathing during sleep
1 2 3 4 5 ___ Breathe irregularly during sleep
1 2 3 4 5 ___ Awaken due to choking or gagging
1 2 3 4 5 ___ Have trouble lying flat
1 2 3 4 5 ___ Have dry mouth in the morning
1 2 3 4 5 ___ Have morning headaches

Parasomnias:

1 2 3 4 5 ___ Have vivid dream recollection
1 2 3 4 5 ___ Have frequent nightmares
1 2 3 4 5 ___ Physically act out dreams
1 2 3 4 5 ___ Sleep walk
1 2 3 4 5 ___ Sleep talk
1 2 3 4 5 ___ Awaken confused or disoriented

Miscellaneous:

1 2 3 4 5 ___ Grind teeth at night
1 2 3 4 5 ___ Jaw pain in the morning
1 2 3 4 5 ___ Wake with heartburn
1 2 3 4 5 ___ Have night sweats
1 2 3 4 5 ___ Have pets in the bedroom
1 2 3 4 5 ___ Leave the TV on while sleeping
1 2 3 4 5 ___ Have chronic pain that disrupts sleep
1 2 3 4 5 ___ Have palpitations at night

Narcolepsy:

1 2 3 4 5 ___ Have sleep attacks (or uncontrollable urges to sleep) during the day
1 2 3 4 5 ___ Feel knees buckle, arms weaken, or jaw drop when happy, mad, or sad
1 2 3 4 5 ___ Feel paralyzed upon waking or falling asleep
1 2 3 4 5 ___ Hallucinate (see or hear something which isn't really there) when waking or falling asleep
1 2 3 4 5 ___ Experience vivid dream like scenes upon awakening or falling asleep

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Medications

Please list all medication allergies:

Please provide a complete list of medications with dosing information:

Medication Name	Dose	Frequency