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SLEEP MEDICINE HISTORY FORM

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_ SEX: \_\_\_\_\_\_\_\_

WEIGHT: \_\_\_\_\_\_\_\_\_LBS HEIGHT: \_\_\_\_\_\_FT \_\_\_\_\_\_IN NECK (COLLAR) SIZE: \_\_\_\_\_\_\_\_\_IN

SOCIAL SECURITY #: \_\_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_

PRIMARY CARE PROVIDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Circle the Appropriate Response**

Do you use oxygen? YES NO If yes, how many liters? \_\_\_\_\_\_\_\_ Nighttime only/day use also.

**SLEEP ROUTINE:**

1. What time do you go to bed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How long does it take for you to fall asleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	1. What occurs during that time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you frequently wake up in the middle of the night? YES/NO
	1. If yes, how many times? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. What is the reason for waking up during the night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	3. How long does it take you to return to sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What TIME do you WAKE UP in the morning? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Do you feel REFRESHED UPON WAKING UP? YES/NO
6. Do you take any:
	1. Scheduled/Planned Naps? YES/NO When & How Long\_\_\_\_\_\_\_\_
	2. Unscheduled/Unplanned Naps? YES/NO \_\_\_\_\_When Driving

 \_\_\_\_\_When Inactive

 \_\_\_\_\_In Conversations

* 1. IF YES, Do you feel refreshed after the nap? YES/NO
1. Any change in sleep schedule on your DAYS OFF? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you recently had any change in your WEIGHT? GAINED/LOST How Much? \_\_\_

**SLEEP APNEA SYMPTOMS:**

1. Has anyone told you that you SNORE? YES/NO
	1. If YES, How LOUD? MILD/MODERATE/LOUD

Has anyone seen you STOP BREATHING

Or have pauses in breathing when you sleep? YES/NO

1. Do you wake up from sleep with a

CHOKING/GAGGING sensation? YES/NO

1. Has anyone told you that you make

SNORTING/GASPING noises in sleep? YES/NO

1. Do you wake up with a DRY MOUTH? YES/NO
2. Do you wake up with a HEADACHE? YES/NO
3. Do you DROOL on the pillow? YES/NO
4. Do you feel TIRED during the day? NO/MILD/MOD/SEVERE

**RESTLESS LEGS:**

1. Do you have UNCOFORTABLE SENSATIONS

In your legs before bedtime? YES/NO

1. If YES, please describe them. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you have any of the following during sleep?
	1. SLEEPWALKING YES/NO
	2. SLEEP TALKING YES/NO
	3. FREQUENT NIGHTMARES YES/NO
	4. ACTING OUT DREAMS YES/NO

**SLEEP HYGIENE:**

1. Do you do any of these activities in your bedroom?

a. WATCH TV YES/NO

b. EAT YES/NO

c. READ YES/NO

2. Do you drink coffee/caffeinated beverages? NEVER/OCCAS/MODERATE

3. Do you SMOKE? NEVER/FORMER/CURRENT

4. Do you drink ALCOHOL? NEVER/OCCAS/MODERATE

5. Do you use illicit drugs? YES/NO Type\_\_\_\_\_\_\_\_\_\_\_\_

**MISCELLANEOUS:**

1. When FALLING ASLEEP or WAKING UP
2. Do you ever SEE o HEAR things? YES/NO

If yes, Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you ever FEEL PARALYZED? YES/NO
2. Do you ever feel SUDDEN MUSCLE WEAKNESS

When laughing? YES/NO

**DRUG ALLERGIES:** Check box if no known allergies to medications [ ]

1. Drug Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What Reaction?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Drug Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What Reaction?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Drug Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What Reaction?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY:**

1. Does anyone in your family have sleep apnea,

insomnia, restless legs, or narcolepsy? YES/NO

1. If YES, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICATIONS:** Please list all of your current medications:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a SLEEP STUDY before? NO/YES WHERE?\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY:**

[ ]  Hypertension (high blood pressure) [ ]  Nasal Allergies/nasal congestions [ ]  Thyroid disease

[ ]  Heart attack [ ]  Congestive heart failure [ ]  Diabetes

[ ]  Cardiac arrhythmias [ ]  Stroke/TIA [ ]  Heartburn/reflux

[ ]  Atrial Fibrillation [ ]  Pulmonary hypertension [ ]  Fibromyalgia

[ ]  Lung problems/COPD/Asthma [ ]  Anemia/iron deficiency [ ]  Menopause

[ ]  Parkinson’s Disease [ ]  Seizures [ ]  Cancer

[ ]  Arthritis [ ]  Autoimmune disease [ ]  Broken nose

[ ]  Depression/Anxiety/bipolar [ ]  End stage kidney disease/dialysis [ ]  Head injury

[ ]  Chronic Pain (reason) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SURGERIES:**

Please list all of your surgeries

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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