Have you been previously evaluated for a sleep disorder: YES NO If yes, what year, at what institution, and what were the findings: ________________________________

Height: ___________________________ Weight: ________________________________

Medical History (list conditions, high blood pressure, diabetes, asthma, etc.): __________________

_____________________________________________________________________________________________________

Medications including oxygen (list medications – both prescription and over the counter): ______________

_____________________________________________________________________________________________________

Do you have allergies? : YES NO If yes, describe: ________________________________

Do you have a known cardiac arrhythmia? YES NO If yes, what type? ________________________________

Do you suffer from seizure disorder? YES NO If yes, are you being treated? YES NO

If awoken from sleep, do you have any violent tendencies we should know about? YES NO If yes, please describe: ________________________________

Consume ____________ alcoholic beverages/day and ____________ caffeinated beverages/day

Average tobacco use: ____________ cigarettes/day

Marital status: (circle one) married single divorced widowed significant other

Name of children and their ages: ________________________________

Occupation: ________________________________

Does your job involve shift work? YES NO If yes, please describe: ________________________________

(continued on reverse)
Weekdays
Usual bedtime: ____________________ am/pm  Usual awakening time: ____________________ am/pm

Weekends
Usual bedtime: ____________________ am/pm  Usual awakening time: ____________________ am/pm

On average how many times do you awaken during the night? ________________________________

If you have a bed partner, have they noticed you doing any of the following during your sleep? (circle)

Stop breathing    Snore    Have gasping arousals    Talking
Jerk your legs    Walking    Grind your teeth    Thrash around

Other: ________________________________________________________________

Do you suffer from any of the following? (circle)

Excessive daytime sleepiness    Difficulty initiating sleep    Difficulty maintaining sleep
Frequent nocturnal awakenings    Gasping arousals from your sleep    Leg cramps (charlie horses)
Nasal congestion    Mouth breathing    Heart Burn

Restless legs at sleep onset (discomfort in your limbs that make you need to move around)

Attacks of sudden, brief losses of muscle strength (cataplexy)

Vivid dream-like scenes when drowsy (hypnagogic hallucinations)

Paralysis just prior to falling asleep or upon awakening (sleep paralysis)

Awake from sleep screaming, violent, and confused (night terrors)

How many times have you ever been involved in automobile accidents, or near accidents, because of sleepiness? ________________________________ times

How many daytime naps do you take? ________________________________

Average total time napping during the day ________________________________ minutes/hours

Is there anything else not covered by this questionnaire regarding your sleeping or waking problem that you would like us to know? ________________________________

__________________________
__________________________

Date Time Signature

01/15 MC 0271