Lexington Sleep Solutions

LexingtonSleepSolutions.com

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Lexington Medical Center

Patient Sleep History and Physical

Name:_____

Age:_____ Date:_____ Referring Physician:_____

Have you ever had a sleep study?

If so, when?_____ And where? _____

Do you snore? ☐ Yes ☐ No ☐ I don't know ☐ Sometimes

How long ago did it start? _____

Is it worsening? ☐ Yes ☐ No

Has anyone ever noticed if you stop breathing? ☐ Yes ☐ No

Do you gasp or choke while you sleep? ☐ Yes ☐ No

Do you and your bed partner sleep in separate rooms because of your snoring?

☐ Yes ☐ No

Do you suffer from morning headaches? ☐ Yes ☐ No

Do you feel sleepy during the daytime? ☐ Yes ☐ No

Do you get up to go to the bathroom at night? ☐ Yes ☐ No

If so, how many times?_____

Have you gained any weight over the last year? ☐ Yes ☐ No

If so, how much?_____

Do you ever get sleepy driving? ☐ Yes ☐ No

Are there times when you have difficulty concentrating in the afternoon?
☐ Yes ☐ No

Do you suffer from memory problems? ☐ Yes ☐ No ☐ I don't know

Do you get irritable easily? ☐ Yes ☐ No

Do you take any daytime naps? ☐ Yes ☐ No

Do you ever experience restlessness or discomfort in your legs? ☐ Yes ☐ No

Do you move or kick your legs while sleeping? ☐ Yes ☐ No

Have you ever felt the sudden loss of strength (arms, legs) in response to some emotional experience? ☐ Yes ☐ No

Do you ever have bizarre dreams? ☐ Yes ☐ No

Have you ever lain in bed awake and felt paralyzed?
☐ Yes ☐ No

How likely are you to doze off or fall asleep? Please use the following scale:

0 = would never doze 2 = moderate chance of dozing

1 = slight chance of dozing 3 = high chance of dozing

_____ sitting and reading
_____ watching television
_____ sitting inactive in a public place
_____ while a passenger in a car without a break
_____ laying down to rest in the afternoon when circumstances permit
_____ sitting and talking to someone
_____ sitting quietly after lunch without alcohol
_____ in a car, while stopped in traffic for a few minutes

Epworth score:_____ **Date:**_____

Tell us about your sleep schedule:

What is your bedtime?_____

What time do you get up?_____

How long does it take you to fall asleep?_____

Do you wake up in the middle of the night? ☐ Yes ☐ No

How many times per night? _____

Do you fall asleep again easily? ☐ Yes ☐ No

CONTINUED ON BACK

PAST MEDICAL HISTORY

Are you being treated now or have you ever been treated for the following? Please check or list.

☐ Hypertension ☐ GERD ☐ Severe Arthritis ☐ Diabetes

☐ Heart Disease ☐ Fibromyalgia ☐ Asthma/COPD

☐ Lower Back Pain ☐ Other _____

Have you ever had any operations? Any injuries?

_____

_____

_____

Check if any close family member (parents, brothers and sisters, children) have:

☐ Sleep Apnea ☐ Heartburn ☐ High Blood Pressure

☐ Heart Problems ☐ Diabetes

Are there any other health problems in your family?

_____

_____

_____

_____

SOCIAL HISTORY

Marital Status: ☐ S ☐ M ☐ W ☐ D

With whom do you live?_____

What is your occupation?_____

Do you smoke? ☐ Yes ☐ No

How long?_____ How much?_____

Have you quit? ☐ Yes ☐ No If so, when?_____

Do you drink alcohol? ☐ Yes ☐ No

How long?_____ How much?_____

Have you quit? ☐ Yes ☐ No If so, when?_____

Do you drink caffeinated beverages? ☐ Yes ☐ No

How much?_____

Do you take any medications at bedtime? ☐ Yes ☐ No

If so, what and how much?

_____

_____

_____

REVIEW OF SYMPTOMS (Please circle any symptom you have, so we can find out more about it)

Eye problems	such as double or blurred vision; glaucoma; cataracts
Hearing problems	buzzing or ringing in ears
Allergies; hay fever; Sinus problems	
Blood pressure or heart problems	
Asthma; tuberculosis; emphysema; chronic bronchitis	
Stomach problems	heartburn; indigestion; change in bowel habits
Bloody or tarry stools; jaundice; liver problems; ulcers; gallstones	
Urinary problems	frequency; infections; stones; bladder; bed wetting Men: prostate problems; night-time urination Women: abnormal menstrual periods; could you be pregnant
Joint pains	swelling or redness; arthritis; back pain
Muscle aches or tenderness; gout; arthritis	
Rash, itching or other skin problems	
Women: breast lumps; recent mammogram, pap smear and/or pelvic exam	
Paralysis (even temporary); stroke; numbness; loss of balance	
Seizures; loss of memory; headaches	
Unusual thoughts; nervousness; crying or sadness; depression	
Thyroid disorder; diabetes; excess thirst; excess hunger or urination	
Bleeding; easy bruising; risk factors for HIV; anemia; cancer	