NAME: _____ AGE: _____

BIRTH DATE: _____ SEX: ❑ MALE ❑ FEMALE

HEIGHT: _____ WEIGHT: _____

PRIMARY PHYSICIANS: _____

OTHER PHYSICIANS: _____

Please list your current prescriptions and over-the-counter medications:

MEDICATION	DOSAGE

MEDICATION	DOSAGE

Patient Label

Do you have a history of any of the following (*please check Yes or No*):

Hypertension	❑ Yes	❑ No	Overweight	❑ Yes	❑ No
Seizures	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No
Smoking	❑ Yes	❑ No	Psychiatric Disorder	❑ Yes	❑ No
Stroke	❑ Yes	❑ No	Lung Disease	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Allergies	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Alcohol Usage	❑ Yes	❑ No
Pacemaker Placement	❑ Yes	❑ No	Head/Spinal Injury	❑ Yes	❑ No
Irregular Heartbeat	❑ Yes	❑ No	Asthma	❑ Yes	❑ No
Chronic Obstructive Pulmonary Disease	❑ Yes	❑ No	Sinus Problems	❑ Yes	❑ No
Thyroid Disease	❑ Yes	❑ No	Deviated Nasal Septum	❑ Yes	❑ No
Depression	❑ Yes	❑ No	Tonsillectomy	❑ Yes	❑ No
Bladder Problems	❑ Yes	❑ No	Fibromyalgia	❑ Yes	❑ No
Gastric Reflux	❑ Yes	❑ No	AIDS	❑ Yes	❑ No

Do you have a history of any of the following (*please check Yes or No*):

1. Are you on a regular sleep/wake schedule?	❑ Yes	❑ No
2. Do you take sleep medication more than twice a week?	❑ Yes	❑ No
3. Do you have trouble going to sleep?	❑ Yes	❑ No
4. If you are awakened, do you have trouble getting back to sleep?	❑ Yes	❑ No
5. Do you have to wake up in the middle of the night to go to the bathroom?	❑ Yes	❑ No
6. Do you ever feel tired without any reason?	❑ Yes	❑ No
7. Do you fall asleep while:		
• Driving a car?	❑ Yes	❑ No
• Eating?	❑ Yes	❑ No
8. Do you have sleep attacks (episodes of irresistible sleep) during the day?	❑ Yes	❑ No
9. Do you dream very real visual hallucinations?	❑ Yes	❑ No
10. Do you experience restlessness in your legs during the day or night?	❑ Yes	❑ No
11. Do you snore?	❑ Yes	❑ No

Patient Label

Do you have a history of any of the following (*please check Yes or No*):

12. Has your bed partner or anyone else noticed that during your sleep you stop breathing for more than 10 seconds? ❑ Yes ❑ No

13. Do you sweat at night? ❑ Yes ❑ No

14 Do you awaken with any of the following:
- Feeling of smothering? ❑ Yes ❑ No
- Feeling of choking? ❑ Yes ❑ No
- A loud snort? ❑ Yes ❑ No
- Wheezing? ❑ Yes ❑ No
- Gagging? ❑ Yes ❑ No
- A morning headache? ❑ Yes ❑ No
- A raw irritable throat? ❑ Yes ❑ No
- A feeling as if your throat has closed off? ❑ Yes ❑ No
- Flailing or bolting upright? ❑ Yes ❑ No

15. Do you grind your teeth? ❑ Yes ❑ No

16. Do you experience any of the following during your sleep:
- Sleepwalking? ❑ Yes ❑ No
- Nightmares more than twice a week? ❑ Yes ❑ No
- Confusion upon wakening? ❑ Yes ❑ No
- Screaming or jumping out of bed/hitting your bed partner? ❑ Yes ❑ No

17. Are you under a great deal of stress at work or home? ❑ Yes ❑ No

18. Do you drink coffee, tea or colas in the afternoon or evening? ❑ Yes ❑ No

19. Do you smoke tobacco products at bedtime? ❑ Yes ❑ No

20. Fall Risk:
- Have you fallen in the last 3 months? ❑ Yes ❑ No
- Do you feel unsteady when you walk? ❑ Yes ❑ No
- Do you use anything to help you walk? ❑ Yes ❑ No

21. Abuse Screen:
- Do you feel unsafe at home or work? ❑ Yes ❑ No
- Do you feel threatened by someone? ❑ Yes ❑ No
- Does anyone try to keep you from having contact with others or doing things outside your home? ❑ Yes ❑ No

Patient Label

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze or fall asleep in the following situations, in contrast to just feeling 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 work out how they have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = No chance of dozing

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 public space (e.g., a theater or a meeting)	
Riding 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 to someone	
Sitting quietly after a lunch without alcohol	
Riding in a car, while stopped for a few minutes in traffic	

NOTES:

Patient Label