SLEEP MEDICAL HISTORY

Patient Name: ____

Referring Doctor: ____

Age:_______ Sex:________ Date History Form filled out:_________________
Ht :_______ Wt:________ BMI:_______ ESS:_______ Sleep Study?_______(HST or overnight)
What is it about your sleep that you are seeing the doctor?

____

GENERAL SLEEP QUESTIONS:
Do you have a history of heart attack, stroke, diabetes or high blood pressure? YES NO
Do you have a history of surgery to the Nose, Throat or Tongue? Type? YES NO __________
Have you been told you snore (Observed Snoring)? YES NO
Have you been told you stop breathing (Observed Apnea)? YES NO
Are you tired during the day (Daytime Tiredness)? YES NO
If you are tired during the day: YES NO
Are you tired in the Morning? YES NO
Are you tired in the Afternoon? YES NO
Are you tired in the early Evening? YES NO
Do you fall asleep easily? YES NO
Do you fall asleep too easily, like during the day, or at work or while driving? YES NO
Do you have trouble falling asleep? YES NO
Do you Dream at Night? YES NO
Do you have trouble awakening? YES NO
Do you have to keep an alarm? YES NO
Do you sleep though the alarm? YES NO
Do you have trouble staying asleep once you fall asleep (Frequent Awakenings)? YES NO
Do you use Caffeine/Other means to stay awake? YES NO
What? How often? _________________________

Do you use medications/Drugs/Alcohol to get to sleep? YES NO
How often? Please list__________________

Other:____
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