DEMERA

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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:_____
_____