Name:_____ DOB:_____
First Middle Last

Pharmacy Name and Address: _____

Do you have a problem now or in the past with any of the following?
(Check all that apply)

___ Anemia	___ Hay fever	___ Phlebitis, blood clots
___ Prostate problems	___ Heart attack/Angina	___ Arthritis
___ Rashes	___ Heart disease	___ Asthma
___ Rheumatic fever	___ Heart murmur	___ Bone fractures
___ Seizures	___ Heart valve disease	___ Bronchitis
___ Sinusitis	___ High blood pressure	___ Cancer
___ Sleep problems	___ Irregular heartbeat	___ Depression
___ Stroke or TIA's	___ Kidney stones	___ Diabetes
___ Thyroid problems	___ Nervousness	___ Emphysema
___ Ulcers	___ Pneumonia	___ Gout
___ Urine infections	___Other	

ALLERGIES

Are you allergic to any medications? ☐ YES ☐ NO If yes, please list below:

Medicine: _____ Reaction: _____

Medicine: _____ Reaction: _____

Are you allergic to any foods, dyes, or other?

Please explain:

_____

IMMUNIZATIONS

Do you get the Influenza vaccine every year? ☐ YES ☐ NO Date last received: _____
Have you ever had the Pneumonia vaccine? ☐ YES ☐ NO Date last received: _____
Have you ever had the TB skin test? ☐ YES ☐ NO Date last received: _____

FAMILY HISTORY

	Age	Alive (yes or no)	Medical Problems	Cause of Death

Father: _____

Mother: _____

Sibling: _____

Sibling: _____

Child: _____

Child: _____

Birthplace: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Occupation: _____

MEDICAL PROBLEMS

_____

_____

_____

SURGERIES

	Year	Where

_____

_____

_____

_____

_____

HOSPITALIZATIONS

	Year	Where

_____

_____

_____

_____

Initials: _____ Date: _____

How did you first hear about our sleep center?

- ❑ Physician
- ❑ Relative
- ❑ Friend
- ❑ Newspaper/Journal/Magazine/T.V. _____
- ❑ Radio
- ❑ Seminar
- ❑ Sleep Society
- ❑ Other: _____

1. Describe your main problem(s) in your own words, including when and how this began and what treatment you have received for this in the past.

2. How often does this problem occur?

   - ❑ Almost every night
   - ❑ For periods of at least one week
   - ❑ Irregularly
   - ❑ Other_____

3. How long has this problem bothered you?

   - ❑ Longer than 2 years
   - ❑ 1 to 2 years
   - ❑ Several months
   - ❑ Within the last 3 months
   - ❑ Within the last month

4. On the scale below, please estimate the severity of your problem(s)

_____	_____	_____	_____	_____
Mildly Upsetting	Moderately Upsetting	Very Severe	Extremely Severe	Totally Incapacitated

5. How strongly do you want help with your sleep problems?

_____	_____	_____	_____
Very Much	Much	Moderately	Could do Without

Initials: _____ Date: _____

6. How do you describe your sleep problems? (Check all that apply)

   - ❑ Difficulty falling asleep
   - ❑ Wake up during the night
   - ❑ Wake up early in the morning
   - ❑ Excessive daytime sleepiness
   - ❑ Difficulty awakening

7. Do any other members of your family have sleep problems? Please explain:

8. Have you ever consulted with any of the following to help you with a sleep problem or daytime sleepiness?

   - ☐ General Practitioner
   - ☐ Obstetrics/Gynecology
   - ☐ Cardiologist
   - ☐ Other Internist
   - ☐ Psychiatrist
   - ☐ Other Physician
   - ☐ Clinical Psychologist
   - ☐ Chiropractor
   - ☐ Osteopath
   - ☐ Nutritionist
   - ☐ Counselor
   - ☐ Social Worker
   - ☐ Nurse
   - ☐ Clergyman

   - Other_____

9. What treatments have you received?

10. Please rate how often you do the following:

	Never	Rarely	Sometimes	Frequently	Constantly
Awaken from sleep Short of breath	_____	_____	_____	_____	_____
Awaken at night with Heartburn, belching, or Cough	_____	_____	_____	_____	_____

Initials: _____ Date: _____

	Never	Rarely	Sometimes	Frequently	Constantly
Snore	_____	_____	_____	_____	_____
Snore loudly enough That others complain	_____	_____	_____	_____	_____
Have trouble sleeping When you have a cold	_____	_____	_____	_____	_____
Suddenly wake up Gasping for breath During the night	_____	_____	_____	_____	_____
Have breathing problems At night (observed by self Or others)	_____	_____	_____	_____	_____
Sweat excessively at Night	_____	_____	_____	_____	_____
Notice your heart pounding Or beating irregularly during The night	_____	_____	_____	_____	_____
Fall asleep during the day	_____	_____	_____	_____	_____
Fall asleep involuntarily	_____	_____	_____	_____	_____
Fall asleep while Driving	_____	_____	_____	_____	_____
Fall asleep during Physical effort	_____	_____	_____	_____	_____
Fall asleep when laughing Or crying	_____	_____	_____	_____	_____
Experience loss of Muscle tone when Extremely emotional	_____	_____	_____	_____	_____
Have trouble at school Or work because of Sleepiness	_____	_____	_____	_____	_____
Feel unable to move (paralyzed) when waking or falling asleep	_____	_____	_____	_____	_____

Initials: _____ Date: _____

Experience vivid dream- Like scenes upon Awakening or falling asleep	_____	_____	_____	_____	_____

Feel afraid of going to sleep	_____	_____	_____	_____	_____
Have nightmares	_____	_____	_____	_____	_____
Remember your dreams	_____	_____	_____	_____	_____
Have thoughts racing Through your mind	_____	_____	_____	_____	_____
Feel sad and depressed	_____	_____	_____	_____	_____
Have anxiety (worry About things)	_____	_____	_____	_____	_____
Have muscular tension	_____	_____	_____	_____	_____
Notice parts of your Body jerk	_____	_____	_____	_____	_____
Experience crawling and Aching feelings in your Legs	_____	_____	_____	_____	_____
Experience any type of leg Pain during the night	_____	_____	_____	_____	_____
Have morning jaw pain	_____	_____	_____	_____	_____
Grind teeth during sleep	_____	_____	_____	_____	_____
Are bothered by pain During the day	_____	_____	_____	_____	_____
Are awakened by pain During the night	_____	_____	_____	_____	_____
Wake up feeling stiff In the mornings	_____	_____	_____	_____	_____
Wake up with sore or Achy muscles	_____	_____	_____	_____	_____
Wake up with pain in Neck, spine or joints	_____	_____	_____	_____	_____

Initials: _____ Date: _____

11. Is your present work situation satisfactory?

12. Check any of the following that apply to you

- ☐ Headaches
- ☐ Palpitations
- ☐ Bowel Disturbances
- ☐ Nightmares
- ☐ Feel tense
- ☐ Depressed
- ☐ Unable to relax
- ☐ Don't like weekends and vacations
- ☐ Can't keep a job
- ☐ Financial problems
- ☐ No Appetite
- ☐ Alcoholism
- ☐ Take drugs
- ☐ Can't make decisions
- ☐ Unable to have a good time
- ☐ Take antacids regularly (tums, tagamet, etc)
- ☐ Dizziness
- ☐ Stomach trouble
- ☐ Fatigue
- ☐ Take sedatives
- ☐ Feel panicky
- ☐ Suicidal thoughts
- ☐ Sexual problems
- ☐ Overambitious
- ☐ Memory Problems
- ☐ Inferiority feelings
- ☐ Fainting spells
- ☐ Insomnia
- ☐ Tremors
- ☐ Shy with people
- ☐ Home conditions bad
- ☐ Concentration difficulties
- ☐ Other

13. Circle any of the following words that apply to you:

Worthless Useless a "nobody" "life is empty" Inadequate stupid

Incompetent naïve "can't do anything right" Guilty Evil Morally wrong

Horrible thoughts Hostile full of hate Anxious Agitated Cowardly

Unassertive Panicky Aggressive Ugly Deformed Lonely Unloved

Misunderstood Bored Restless Confused Unconfident In conflict

Full of regrets Worthwhile Sympathetic Intelligent Attractive

Confident Considerate Other_____

14. Does your sleep problem disturb your sex life? (Provide any information about any significant relationships.)

Initials: _____ Date: _____

15. Is your present social life satisfactory? Does your sleep problem require you to cut back on social activity? If so, how?

16. How many hours do you usually sleep per night? _____

17. What time do you usually go to bed on Weekdays? _____ Weekends? _____

18. How long does it take for you to fall asleep?_____

19. How many times do you typically wake up at night?_____

20. If you wake up, on the average, how long to you stay awake?_____

21. If you do waken during the night (after you first fall asleep) which part(s) of your sleep period is it?

- ❑ Soon after falling asleep
- ❑ Middle of the night
- ❑ Early morning

22. What do you usually do when you awaken during the night?_____

_____

23. What time do you usually awaken in the morning on Weekdays? _____ Weekends? _____

24. On the average, how long do you stay in the bed after waking up in the morning? _____

25. Do you usually: (check all that apply to you)

- ❑ Sleep with someone else in your bed
- ❑ Sleep with someone else in your room
- ❑ Provide assistance to someone during the night (child, invalid, bed partner, animal)

26. Is your sleep often disturbed by?

- ❑ Heat
- ❑ Cold
- ❑ Noise
- ❑ Light
- ❑ Bed partner
- ❑ Not being in your usual bed
- ❑ Other_____

Initials: _____ Date: _____

27. Are your sleep habits on weekends different from the rest of the week?

- ❑ No
- ❑ Yes – Please describe_____

28. With whom are you now living? (spouse, children, parents, etc.) please list ages

_____

_____

_____

29. Do you work split shifts or rotating (variable) shifts?_____

30. Do you usually drink coffee or tea within 2 hours before you go to bed? ☐ Yes ☐ No

31. Do you perform physical exercise before going to bed? ☐ Yes ☐ No

32. Do you read before falling asleep? ☐ Yes ☐ No

33. Do you watch T.V. in bed before falling asleep? ☐ Yes ☐ No

34. Do you take naps during the afternoon or evening? ☐ Yes ☐ No

35. Do you feel refreshed after a short (10-15) min nap? ☐ Yes ☐ No

36. Do you feel rested after an average night of sleep? ☐ Yes ☐ No

37. Do you feel better during:

- ❑ Morning
- ❑ Afternoon
- ❑ Evening

38. Please list all medications you are currently taking:

Medication	Amount	Frequency	Reason

Initials: _____ Date: _____

39. List your consumption of the following per day:

Coffee_____ Colas_____ Teas_____

Nicotine_____ Alcohol_____ Chocolate_____

Other_____ Over the counter medications_____

40. Have you had a car accident or near-miss crash associated with drowsiness/excessive sleepiness?

Yes _____ No _____

41. What is your personal interpretation as to why you have your particular sleep/wake problems?

42. Please describe any other information pertinent to your sleep wakefulness not previously described.

Initials: _____ Date: _____

THE EPWORTH SLEEPINESS SCALE

Name:_____

Today's Date: _____ Your Age: (years)_____

How likely are you to doze off or just fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent time. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = Would never doze

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

Situation	**Chance of dozing**
Sitting and Reading	_____
Watching T.V.	_____
Sitting, inactive in a public Place (theater or a meeting)	_____
As a passenger in a car for 1 hour without a break	_____
Lying 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 For a few minutes in Traffic	_____

Thank you for your cooperation!

SF-12 Health Survey This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. **Answer each question by choosing just one answer**. If you are unsure how to answer a question, please give the best answer you can.

Patient name:

_____

Date: _____

1. **In general, would you say your health is**:
   □1 Excellent □2 Very good □3 Good □4 Fair □5 Poor

The following questions are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?

	YES, limited a lot	**YES, limited a little**	**NO, not limited at all**
2. **Moderate activities** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	□1	□2	□3
3. Climbing **several** flights of stairs.	□1	□2	□3

During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities <u>because of your physical health</u>?

	YES	**NO**
4. **Accomplished less** than you would like.	□1	□2
5. Were limited in the **kind** of work or other activities.	□1	□2

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities because of any emotional problems (such as feeling depressed or anxious)?

	YES	NO
6. **Accomplished less** than you would like.	☐1	☐2
7. Did work or activities **less carefully than usual**.	☐1	☐2

8. **During the past 4 weeks, how much did pain interfere with your normal work (including work outside the home and housework)?**

☐1 Not at all ☐2 A little bit ☐3 Moderately ☐4 Quite a bit ☐5 Extremely

These questions are about how you have been feeling during the past 4 weeks.
For each question, please give the one answer that comes closest to the way you have been feeling.
How much of the time during the past 4 weeks?

	All the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm & peaceful?	☐1	☐2	☐3	☐4	☐5	☐6
10. Did you have a lot of energy?	☐1	☐2	☐3	☐4	☐5	☐6
11. Have you felt downhearted and blue?	☐1	☐2	☐3	☐4	☐5	☐6

12. **During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?**

☐1 All of the time ☐2 Most of the time ☐3 Some of the time ☐4 A little of the time ☐5 None of the time