



**Southeast Regional Sleep Disorders Center**  
**357 Woodruff Road**  
**Greenville, SC 29607**  
**(864) 62-SLEEP**  
**(864) 627-5337**  
**(800) 290-1349**

## Patient Information/Sleep History

Date: \_\_\_\_\_

Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_  
Home Other

**Email** (This information is not shared or sold to any third party. Email addresses are solely used for alerts and notices of support group meetings)

Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex: Male Female Martial Status \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Referring Physician \_\_\_\_\_ Physician Phone Number \_\_\_\_\_

Family Physician \_\_\_\_\_ Physician Phone Number \_\_\_\_\_

Name of person completing questionnaire, if other than the patient:

Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Relationship to pt \_\_\_\_\_

### Chief Complaints

What are your major complaints related to sleep and wakefulness, and how long have you had them?  
(Use reverse side if necessary)

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**I. Epworth Sleepiness Scale**

	0 = Would never doze
	1 = Slight chance of dozing
	2 = Moderate chance of dozing
	3 = High chance of dozing
<u>Situation</u>	<u>Chance of Dozing</u>
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (i.e. theatre)	_____
As a car passenger for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopping for a few minutes in traffic	_____
	_____ <b>Total Score</b>

**II. SLEEP HABITS**

Bed Time \_\_\_\_\_ Minutes to fall asleep \_\_\_\_\_ Number of Nighttime awakenings \_\_\_\_\_

Number of times to urinate \_\_\_\_\_ Do you have trouble returning to sleep? \_\_\_\_\_

1. What time do you usually get out of bed? \_\_\_\_\_
2. How many hours of actual sleep time do you think you get? \_\_\_\_\_
3. Do you awaken with a headache? \_\_\_\_\_
4. Do you take anything to help you sleep? \_\_\_\_\_ What? \_\_\_\_\_

**III. NARCOLEPSY**

	YES	NO
1. As you fall asleep or wake up, do you have vivid or lifelike visions (people in the room, etc.)?	_____	_____
2. When you laugh, do you feel sudden weakness or have any part of your body go limp (head drop, knees buckle, slurred speech)?	_____	_____
3. As you are trying to go to sleep or wake up, do you ever have an inability to move (sleep paralysis)?	_____	_____
4. Have you ever driven or traveled somewhere and did not remember how you got there?	_____	_____

**IV. Symptom related to sleep.**

**Circle any of the following symptoms that you currently have when sleeping or trying to sleep.**

Unsatisfactory sleep	Trouble falling asleep	Mind races	Fear of inability to sleep
Cannot relax	Easily awakened	Trouble returning to sleep	
Prefer to sleep longer			

**V. Abnormal Sleep Symptoms.**

**Circle any of the following that you experience during sleep.**

Loud snoring	Stop breathing	Choking	Gaspings	Dry Mouth
Struggle to Breathe	Wake self snoring	Gasp for air	Snorting	
Heart burn	Sour belches	Regurgitation		
Urge to move legs	Can't keep legs still	Restless legs		Leg cramps (Frequently)
Aching or crawling sensation in legs		Sleep disturbed by pain (Anywhere)		
Sleep walking or sleep eating		Sleep talking	Nightmares	
Teeth Grinding	Cough	Wheezing	Can't Sleep Flat	
Night Sweats	Hot flashes	Feel cold	Toss and Turn	
Bedwetting	Arms flail	Fall out of Bed		

**VI. Symptoms during wake.**

**Circle any of the following that you experience while awake.**

Feel achy or stiff	Grumpy or irritable	Decreased energy	Headaches
Fatigue	Exhaustion	Sleep	Poor Memory
Poor Concentration	Feel dazed	Sore throat	Low sex drive

**VII. Previous sleep assessment.**

Have you had sleep study?      Yes      No

When - \_\_\_\_\_ Where- \_\_\_\_\_

Psychological test:              Yes      No

Have you had any treatment for a sleep problem?    If so, what? \_\_\_\_\_

**VIII. Psychological symptoms or diagnosis.**

**Circle any that apply.**

Depression	Anxiety	Stress	Bipolar	Personality change
Irritability	Loss of appetite	Other _____		

Patient Name: \_\_\_\_\_

**IX. WEIGHT**

What do you weigh now? \_\_\_\_\_ What did you weigh 2 year ago? \_\_\_\_\_

**X. MEDICAL HISTORY**

Do you have? (Treated or Untreated)

**Circle any that apply.**

High blood pressure	Sinus trouble	Nasal allergies	Asthma
COPD(Emphysema, Bronchitis)	Diabetes	Heart Trouble	Arthritis
Thyroid Trouble	Anemic	Reflux- GERD	Irritable bowel
Chronic Pain			

Have you ever had infectious - mono - hepatitis - meningitis - encephalitis - loss of consciousness?

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List any major surgeries -

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

List any major injuries-

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

List any drugs allergies:

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

List any drugs, medications, hormones etc. you take.

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

When was your last complete physical examination? \_\_\_\_\_

By whom? \_\_\_\_\_

Did you have blood work done?      Yes      No

Have you had thyroid function test?      Yes      No

**XI. SOCIAL AND FAMILY HISTORY**

- Do you currently smoke? \_\_\_\_\_ How many per day? \_\_\_\_\_  
Did you previously smoke? \_\_\_\_\_ How long? \_\_\_\_\_
- Do you drink alcohol? \_\_\_\_\_ How much? \_\_\_\_\_
- How much coffee, tea or caffeinated beverages do you drink? \_\_\_\_\_
  - What do you usually do at work? \_\_\_\_\_
  - What are your working hours? \_\_\_\_\_  
If you do rotating shift work, or have other work schedule changes, turn page over and describe.
- How many people live in your home? \_\_\_\_\_  
Relationships to you: \_\_\_\_\_
- Does any family member (parent, brother, sister, child, etc.) have:  
Sleep Apnea, snore or have restless legs? Who? \_\_\_\_\_

**XI. REVIEW OF SYSTEMS**

Circle if you have any of the following symptoms more than occasionally:

				Other
<b>Constitutional:</b>	fatigue	weight loss	weight gain	_____
<b>Eyes:</b>	blurred vision	double vision	impaired vision	_____
<b>ENT:</b>	sore throat	allergies	sinus trouble	_____
<b>Cardiovascular:</b>	heart disease	chest pain	leg swelling	_____
<b>Respiratory:</b>	shortness of breath	cough	wheezing	_____
<b>GI:</b>	indigestion	diarrhea	reflux	_____
<b>GU:</b>	frequent urination	impotence	kidney impairment	_____
<b>Muscoskeletal:</b>	joint pains	joint deformities	back pain	_____
<b>Skin:</b>	skin rash	itching	skin lesions	_____
<b>Neurological:</b>	dizziness	impaired walking	memory problems	_____
<b>Psychiatric:</b>	depression	anxiety	stress	_____
<b>Endocrine:</b>	cold intolerance	heat intolerance	appetite changes	_____
<b>Hematologic/ Lymphatic:</b>	easy bruising	enlarged lymph nodes	bleeding	_____
<b>Allergies to:</b>	food	drugs	grasses/pollens	_____

List any other symptoms or problems that you may have that are not covered above.  
Elaborate on any symptom indicated above if necessary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_