THE SLEEP CLINIC

at Beavercreek Commons Family Practice

Today's Date: ____/____/____

****Please fill out this form in full, to the best of your knowledge**

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**

CHIEF SLEEP COMPLAINT

BRIEFLY DESCRIBE YOUR PRIMARY SLEEP DISTURBANCE

☐ Difficulty Falling Asleep ☐ Difficulty Staying Asleep ☐ Excessive Daytime Sleepiness
☐ Snoring ☐ Periods of not breathing normally at night
☐ Restless Sleep
☐ OTHER (Please Describe):

MEDICAL HISTORY

Have you ever been diagnosed with any of these conditions? (Check those that apply)	☐ High Cholesterol	☐ Asthma	☐ Stroke
	☐ Hypertension	☐ GERD (heartburn)	☐ Diabetes
	(High Blood Pressure)	☐ TBI	☐ Hypothyroidism
	☐ Heart Failure	☐ PTSD	☐ Depression
	☐ Irregular Heartbeat	☐ Anemia/Low Iron	☐ Anxiety
	☐ Peripheral Vascular Disease	☐ Nightmares	☐ Recent weight gain
	☐ COPD	☐ Headaches	If yes,_____ lbs gained

Please List other chronic Medical Issues:

Social History	Tobacco ☐ Yes ☐ No	If Yes, how many years?		
		How many hours before bedtime is your last use?		
	Caffeine ☐ Yes ☐ No	If Yes, how many beverages per day?		
		How many hours before bedtime is your last use?		
	Alcohol ☐ Yes ☐ No	If Yes, how many beverages per day?		
		How many hours before bedtime is your last use?		
	Exercise ☐ Yes ☐ No	How many minutes per week?		
		How many hours before bedtime is your last use?		
	Supplements ☐ Yes ☐ No	Type:	Use per week?	
		How many hours before bedtime is your last use?		
Work Schedule	Do you work day or night shift?	☐ Day shift ☐ Night shift	Do you work a fixed schedule or change shifts?	☐ Fixed Schedule ☐ Rotating Schedule

FAMILY HISTORY

(Does anyone in your **immediate** Family have any of the following?)

Obstructive Sleep Apnea ☐ Yes ☐ No	Snoring ☐ Yes ☐ No	Narcolepsy ☐ Yes ☐ No
Restless Legs Syndrome ☐ Yes ☐ No	Insomnia ☐ Yes ☐ No	

SLEEP MEDICATIONS

Do you currently use or have used in the past any of the following medications for sleep?

Please **check** all that apply

Medication	***Check one***	***Currently using?***	***If currently using, how often do you take it?***	***Did it help your sleep?***
1. Zolpidem (Ambien)	☐ Yes ☐ No	☐ Yes ☐ No	☐ *<1/wk* ☐ *1/wk* ☐ *2-6/wk* ☐ *7/wk*	☐ Yes ☐ No
2. Eszopiclone (Lunesta)	☐ Yes ☐ No	☐ Yes ☐ No	☐ *<1/wk* ☐ *1/wk* ☐ *2-6/wk* ☐ *7/wk*	☐ Yes ☐ No
3. Zaleplon (Sonata)	☐ Yes ☐ No	☐ Yes ☐ No	☐ *<1/wk* ☐ *1/wk* ☐ *2-6/wk* ☐ *7/wk*	☐ Yes ☐ No
4. Trazadone	☐ Yes ☐ No	☐ Yes ☐ No	☐ *<1/wk* ☐ *1/wk* ☐ *2-6/wk* ☐ *7/wk*	☐ Yes ☐ No
4. Amitriptyline (Elavil)	☐ Yes ☐ No	☐ Yes ☐ No	☐ *<1/wk* ☐ *1/wk* ☐ *2-6/wk* ☐ *7/wk*	☐ Yes ☐ No
5. Quetiapine (Seroquel)	☐ Yes ☐ No	☐ Yes ☐ No	☐ *<1/wk* ☐ *1/wk* ☐ *2-6/wk* ☐ *7/wk*	☐ Yes ☐ No
6. Diphenhydramine (Benadryl)	☐ Yes ☐ No	☐ Yes ☐ No	☐ *<1/wk* ☐ *1/wk* ☐ *2-6/wk* ☐ *7/wk*	☐ Yes ☐ No
7. Melatonin	☐ Yes ☐ No	☐ Yes ☐ No	☐ *<1/wk* ☐ *1/wk* ☐ *2-6/wk* ☐ *7/wk*	☐ Yes ☐ No
8. Other:	☐ Yes ☐ No	☐ Yes ☐ No	☐ *<1/wk* ☐ *1/wk* ☐ *2-6/wk* ☐ *7/wk*	☐ Yes ☐ No

SURGICAL HISTORY

Have you had surgery on your **upper airways**?	(tonsillectomy, septoplasty, UPPP, sinuses, etc)	☐ Yes	☐ No

Year	Type of Surgery	Why?

Have you ever had a **sleep study**?	☐ Yes	☐ No

If Yes:	When?	What was the diagnosis?
If Yes:	Do you have a CPAP? Yes / No	Does it help? Yes / No

SLEEP-RELATED SYMPTOMS

Please answer by checking YES or NO

Difficulty falling asleep?	☐ Yes ☐ No	Uncontrollable urge to sleep	☐ Yes ☐ No
Difficulty staying asleep	☐ Yes ☐ No	Muscle weakness w/ emotional experience	☐ Yes ☐ No
Wake up frequently at night	☐ Yes ☐ No	Your brain wakes up before your body and you can't move	☐ Yes ☐ No
Snoring	☐ Yes ☐ No	Fall asleep unexpectedly	☐ Yes ☐ No
Non-refreshing sleep	☐ Yes ☐ No	Vivid dreaming at sleep onset	☐ Yes ☐ No
Daytime sleepiness	☐ Yes ☐ No	Legs feel restless	☐ Yes ☐ No
Stop breathing at night	☐ Yes ☐ No	Unpleasant sensation in legs	☐ Yes ☐ No
Waking up short of breath	☐ Yes ☐ No	Sensation is worse at night	☐ Yes ☐ No
Waking up choking/gasping	☐ Yes ☐ No	Sensation worse with inactivity	☐ Yes ☐ No
Heartburn at night	☐ Yes ☐ No	Sensation improves with movement	☐ Yes ☐ No
Nighttime Nasal congestion	☐ Yes ☐ No	Sleep walking	☐ Yes ☐ No
Sweaty at night	☐ Yes ☐ No	Sleep talking	☐ Yes ☐ No
Dry mouth in the morning	☐ Yes ☐ No	Unusual movements during sleep	☐ Yes ☐ No
Urination at night If yes, average # per night	☐ Yes ☐ No _____/ Night	Dream enacting behavior	☐ Yes ☐ No

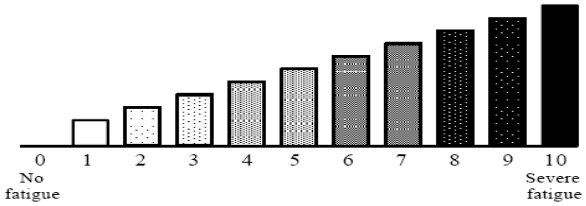
SLEEP-WAKE SCHEDULE

Please describe your typical sleep period

WeekDAYS		**WeekENDS** ☐ Check box if the same as weekdays	
Average Bedtime? (In bed with intent to fall asleep)	o'clock	Average Bedtime? (In bed with intent to fall asleep)	o'clock
How long does it take you to initially fall asleep?	minutes	Final wake time?	o'clock
Final wake time?	o'clock	Do you nap on the weekends?	☐ Yes ☐ No
Average # of nighttime awakenings?		If yes, what time and how long do you nap?	
On average, how long does it take to return to sleep?			

FATIGUE

Please **circle** the number to the right that describes your fatigue over the past 2 weeks.



EPWORTH SLEEPINESS SCALE

How likely are you to fall asleep in the following situations?

0 = never 1 = slight chance 2 = moderate chance 3 = high chance

Situation	**Chance of Dozing** (Circle One)			
1. Sitting and reading	0	1	2	3
2. Watching TV	0	1	2	3
3. Sitting, inactive in a public place (e.g. theater or a meeting)	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon when circumstances permit	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after a lunch without alcohol	0	1	2	3
8. In a car, while stopped for a few minutes in the traffic	0	1	2	3
TOTAL SCORE =				/24

OFFICE USE ONLY:

Neck: MMP:

Follow-up	**_____ weeks** **_____ Bring CPAP/Data Card to next visit**			
Dx/CPAP/BiPAP PSG	**Home Sleep Test**	**Sleep Log**	**Actigraphy**	**Overnight Pulse Ox**
APAP	**Rx ____ - ____ cm H2O**			