Name: _____ D.O.B: _____ Age: ____ Gender: M F Date of Service: _____

ACHC ACCREDITED

Owensboro Advanced Sleep Center

Describe your sleep problem and how long you've had it_____

_____

_____

Have you ever been seen at a sleep center before? YES NO When? _____

Where? _____ Have you ever been on CPAP? YES NO

Work Schedule:

When does your usual work shift start? _____ AM or PM

When does your usual work shift end? _____ AM or PM Do you do shift work? YES NO

Sleep Schedule:	**Weekday**	**Weekend**	**Weekday**	**Weekend**
Average Time you go to bed	_____	_____	Time you get up _____	_____

How long does it take you to go to sleep? _____ minutes How often do you wake up during the night? _____

How many hours do you sleep each night? _____ on average

Do you take planned naps? YES NO How many days per week? _____ On average, how long are naps? _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life recently.

Use the following scale to choose the most appropriate number for each situation:

0 = would NEVER doze **2 = MODERATE chance of dozing**

1 = SLIGHT chance of dozing **3 = HIGH chance of dozing**

Situation

Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place, such as a meeting or church	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you have not had alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3
TOTAL				

Name: _____ D.O.B: _____ Age: ____ Gender: M F Date of Service: _____

Bed Partner Questionnaire: Ask someone familiar with your sleep to answer the following section about you (spouse, parent, child, or other.) ***Name of person filling out this section*** _____

Does the patient…	**Circle Your Answer Below**			
Stop breathing in his/her sleep?	Yes		No	
How often do the pauses in breathing occur?	Every Night		Occasionally	Never
Snore Heavily?	Yes		No	
Make loud snorting or choking noises during sleep?	Yes		No	
Snore Every Night?	Yes		No	
Snore in the follow positions:	Back	Left Side	Right Side	All Positions
Move legs or feet during sleep frequently?	Yes		No	
Violent activity during sleep like punching or kicking?	Yes		No	

Comments _____

SLEEP REVIEW OF SYSTEMS

Are you frequently tired or drowsy during the day?	Yes	No
Have you had any accidents or problems at work due to drowsiness?	Yes	No
Have you had any traffic accidents, near misses or hit the rumble strip due to drowsiness?	Yes	No
Has anyone told you that you snore loudly?	Yes	No
Have you awakened with a dry mouth or "cotton mouth"?	Yes	No
Has anyone told you that you quit breathing or hold your breath at night?	Yes	No
Do you ever wake up choking or gasping?	Yes	No
Do you ever wake up with chest pain?	Yes	No
Do you wake up with heartburn, sour taste in the mouth, burning in the chest or indigestion?	Yes	No
Do you have trouble breathing through your nose at night?	Yes	No
Do you have trouble breathing through your nose during the day?	Yes	No
Do you wake up with headaches?	Yes	No
How many pillows do you sleep on at night?	_____	
How many times do you get up during the night to urinate, on average?	_____	

EXCESSIVE DAYTIME SOMNOLENCE

Do you have any sudden episodes of sleepiness during the day?	**Yes**	**No**
Have you ever had periods in which you feel paralyzed while going to sleep or waking up?	**Yes**	**No**
Have you ever had visual hallucinations or dream-like mental images when falling to sleep?	**Yes**	**No**
Have you ever experienced sudden physical weakness during laughter or strong emotion?	**Yes**	**No**

RESTLESS LEGS

When you try to relax in the evening, do you ever have unpleasant or restless feelings in your legs?	**Yes**	**No**

INSOMNIA Do you take a sleep aid or sleeping pill? **Yes** **No** If Yes, please list: _____

Do you have difficulty falling asleep at night?	**Yes**	**No**
Do you have difficulty staying asleep?	**Yes**	**No**
Do you have pain that bothers you at night?	**Yes**	**No**

MOOD Over the past two weeks, have your felt down, hopeless or depressed? **Yes** **No**

Over the past two weeks, have you felt little interest or pleasure in doing things? **Yes** **No**

Name: _____ D.O.B: _____ Age: ____ Gender: M F Date of Service: _____

PARASOMNIAS

Do you sleepwalk?	**Yes**	**No**	Do you talk in your sleep?	**Yes**	**No**
Do you wet the bed at night?	**Yes**	**No**	Do you act out your dreams during sleep?	**Yes**	**No**
Do you ever wake up screaming?	**Yes**	**No**	Do you have frequent nightmares?	**Yes**	**No**
Do you eat in your sleep?	**Yes**	**No**	Do you grind your teeth in your sleep?	**Yes**	**No**

CHILDHOOD Did you have childhood sleep problems of any type? Yes No
If yes, Describe (such as sleepwalking, bedwetting, sleep terrors) _____

TOBACCO Ever smoked? Yes No If yes, how many years? _____ Packs per day? _____
Do you still smoke? Yes No If no, when did you quit? _____

ALCOHOL/DRUGS Do you drink alcohol? Yes No
If yes, how often? _____ days/week How much on average? _____
Have you ever had a problem with drinking too much alcohol? Yes No

CAFFEINE and OTHER SUBSTANCES

Regular caffeinated coffee?	_____ cups/day		Energy drinks?	Yes	No
Soft drinks with caffeine?	Yes	No	If yes, How many cans of soda per day?	_____	
Do you drink tea with caffeine?	Yes	No	If yes, how many cups/glasses of tea per day?	_____	
Do you currently use street drugs?	Yes	No	Any illicit drug usage in the past?	Yes	No

MEALS/EXERCISE How many meals do you eat daily? _____ Do you exercise regularly? Yes No

WEIGHT CHANGE during past 5 years → Gained _____lbs. or Lost _____lbs.

SOCIAL HISTORY
Occupation: _____ ( ) Retired ( ) Disabled
Marital Status: ( ) Single ( ) Married ( ) Divorced Other: _____
Number of children: _____
Who is currently living in your household? _____

SURGICAL HISTORY *Circle or check all that apply and dates of surgery (year)*

Tonsils & Adenoids	Cardiac Bypass	Gall Bladder
Nose or Sinuses	Appendectomy	Hysterectomy
Back Surgery	Knee or Hip	Other

Other Surgery: _____

OTHER ILLNESSES *Circle or check all that apply*

Diabetes	High Blood Pressure	Emphysema or COPD	Cancer
Stroke	Irregular Heart Beats	High Cholesterol	Kidney Disease
Depression	Coronary Artery Disease	Migraines	Stomach Ulcers/ Reflux
Anxiety	Chronic nasal congestion	Thyroid Disease	Seizures

Other ILLNESSES_____

How did you hear about Owensboro Advanced Sleep Center and/or Dr. Pope?
□ Family □ Friend □ My Doctor □ previously saw Dr. Pope □ Newspaper □ Website □ Facebook □ TV
□ Other (please explain if you wish) _____

Name: _____ D.O.B: _____ Age: ____ Gender: M F Date of Service: _____

REVIEW OF SYSTEMS: Check the boxes of any symptoms that YOU have.

EYES, ENT
- □ Blurry vision
- □ Allergies
- □ Double vision
- □ Dry Eye
- □ Dry mouth
- □ Nose bleed
- □ Nasal congestion
- □ Nasal blockage
- □ Hoarseness
- □ Ear pain
- □ Sore throat
- □ Neck lumps

HEART
- □ Chest pain or heaviness
- □ Swelling of ankles/legs
- □ Racing or pounding heart
- □ Palpitations

STOMACH & GI TRACT
- □ Heartburn
- □ Nausea/Vomiting
- □ Trouble swallowing
- □ Constipation
- □ Diarrhea
- □ Bright blood in stool
- □ Stool black as Tar

MUSCULOSKELETAL
- □ Back Pain
- □ Neck Pain
- □ Arthritis
- □ Joint swelling

PULMONARY
- □ Chronic cough
- □ Cough up phlegm daily
- □ Pleurisy
- □ Cough up blood
- □ Short of breath
- □ Wheezing
- □ Asthma

GENERAL
- □ Weight change
- □ Fatigue
- □ Night sweats
- □ Concentration
- □ Memory Loss

GENITOURINARY
- □ Trouble emptying the bladder
- □ Incontinence
- □ Urgency
- □ Frequent urination during the day
- □ Loss of sex drive or performance

NEUROLOGIC

□ Headaches □ Numbness □ Tingling □ In-coordination □ Dizziness
□ Light headedness □ Imbalance □ Weakness □ Forgetfulness □ Irritability
□ Slurred speech □ Seizures □ Tremors □ Passing out □ Stroke

PSYCHOLOGICAL

□ Personality changes □ Loss of Interest □ Angry □ Withdrawn □ Mood swings
□ Depression □ Suicidal Thoughts □ Sad □ Crying spells □ Nervous

****

FAMILY HISTORY *Circle the Conditions and then List Affected Family Members*

CONDITION	AFFECTED FAMILY MEMBER	CONDITION	AFFECTED FAMILY MEMBER
Diabetes	_____	Narcolepsy	_____
Heart Disease	_____	Daytime Sleepiness	_____
High Blood Pressure	_____	Depression or Anxiety	_____
Stroke	_____	Restless Legs	_____
Obesity	_____	Sleep Apnea	_____

Other – Describe _____

Please bring a current list of your medications (including vitamins and over the counter medications) or the medications in their original containers.

ALLERGIES:

Please List any medication allergies: _____

One final question: What is your goal or what do wish to accomplish by this visit to the Sleep Center?

_____

_____

Thanks for taking the time to complete this Form!!