

NAME:

DOB:

DOS:

AGE:

GENDER:



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 PM

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

SLEEP SCHEDULE

Average time you go to bed

WEEKDAY	WEEKEND

 Time you get up

WEEKDAY	WEEKEND

How long does it take you to go to sleep? _____ minutes

How often do you wake 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 the 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

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BED PARTNER QUESTIONNAIRE: Ask someone familiar with your sleep to answer the following section about you (spouse, parent, child, etc.) **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?	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 hallucination 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 evenings, do you ever have unpleasant or restless feelings in your legs?	Yes	No
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INSOMNIA

Do you take a sleeping 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 you felt down, hopeless or depressed?	Yes	No
Over the past two weeks, have you felt little interest or pleasure in doing things?	Yes	No

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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 any 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 the 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 all that apply and dates of surgery (year)

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

Other Surgery: _____

OTHER ILLNESSES Circle 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 ___ previous patient of Dr. Pope ___ Newspaper ___ Website
___ Facebook ___ TV ___ Other (please explain if you wish)

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REVIEW OF SYSTEMS *Check 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

GENERAL

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

NEUROLOGIC

- Headaches
- Light Headedness
- Slurred speech

PSYCHOLOGICAL

- Personality changes
- Depression

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

GENTOURINARY

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

MUSCULOSKELETAL

- Back pain
- Neck pain
- Arthritis
- Joint swelling

PULMONARY

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

Numbness

Imbalance

Seizures

Tingling

Weakness

Tremors

In-coordination

Forgetfulness

Passing out

Dizziness

Irritability

Stroke

Loss of interest

Suicidal thoughts

Angry

Sad

Withdrawn

Crying spells

Mood swings

Nervous

FAMILY HISTORY *Circle all conditions and then list affected family members*

CONDITION

AFFECTED FAMILY

MEMBER

CONDITION

AFFECTED FAMILY

MEMBER

Diabetes

Heart Disease

High Blood Pressure

Stroke

Obesity

Narcolepsy

Daytime Sleepiness

Depression or Anxiety

Restless Legs

Sleep Apnea

Other- Describe:

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

Thanks for taking the time to complete this questionnaire!