



New Clinic Visit

Sleep Consultation

Patient Form Page 1

Name: _____ Date: _____ Referring MD: _____

Email: _____ DOB: _____ Age: _____ Height: _____ Weight: _____

Occupation: _____

Describe your sleep problem _____

How long ago did the problem begin? _____

Please describe previous evaluation or treatment for this problem _____

- 1) Do you snore? Yes No If yes, mild, moderate, loud; If yes, once or twice/week
 every night
- 2) Has anyone told you that you have stopped breathing? Yes No
- 3) When sitting or lying down, do you have an unpleasant sensation or creepy crawly sensations in your legs? Yes No
- 4) Does the sensation and urge to move come on during periods of rest or inactivity? Yes No
- 5) Are the feelings relieved by movements? Yes No
- 6) Do the sensations and urges to move bother you more in the evening and at night, rather than the daytime? Yes No
- 7) Do you have family members who experience these same sensations and urge to move? Yes No
- 8) Does your bed partner tell you that you jerk your legs during sleep? Yes No
- 9) Do you often have trouble falling asleep or staying asleep? Yes No
- 10) Have you ever suddenly fallen? Yes No
- 11) Have you ever experienced seeing or hearing things that were not real when you were going to sleep or just waking up? Yes No
- 12) Have you experienced sudden body weakness brought on by laughter, surprise or fear? Yes No
- 13) What are your usual working hours? Start ___ am/pm Stop ___ am/pm
- 14) List your sleeping hours for **workdays**: Go to bed ___ am/pm Get up ___ am/pm
- 15) List your sleeping hours for **non-workdays**: Go to bed ___ am/pm Get up ___ am/pm
- 16) How long does it usually take for you to fall asleep after turning out the lights? _____ minutes
- 17) On average, how many times do you **wake up** during the night? _____
- 18) On average, how many times do you **get up** out of bed during the night? _____



- 19) If you get up, what is the reason that wakes you or gets you up? _____
- 20) Do you wake up to early in the morning, unable to return to sleep? Yes No
- 21) How do you ordinarily awaken? Spontaneously; Alarm clock; Other _____
- 22) Do you nap? Yes No How many times a week? _____; If so, for how long? _____
If so, do you find naps refreshing? Yes No
- 23) Do you find yourself falling asleep when you don't intend to? Yes No
- 24) Do you ever fall asleep while driving? Yes No
- 25) Has anyone witnessed apnea? Yes No
- 26) Do you wake up gasping? Yes No
- 27) Does anyone in your family have a sleep disorder? Yes No / If yes, what kind? _____

Please check if the following symptoms if you have had for 2 weeks or more:

<input type="checkbox"/> Loss of energy or feeling tired all of the time	<input type="checkbox"/> Changes in appetite or weight loss or gain
<input type="checkbox"/> Headaches	<input type="checkbox"/> Thoughts of death or suicide, or suicide or suicide attempts.
<input type="checkbox"/> Recent motor vehicle accident	<input type="checkbox"/> Problems concentrating, thinking, remembering, or making decisions
<input type="checkbox"/> Leg Jerking	<input type="checkbox"/> Trouble sleeping
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Feeling hopeless
<input type="checkbox"/> Loss of interest in things you enjoy, including sex.	<input type="checkbox"/> Being anxious
<input type="checkbox"/> Feeling sad, blue or down in the dumps	<input type="checkbox"/> Digestive problem
<input type="checkbox"/> Feeling worthless or guilty	

Social History

- 1) On average, how many alcoholic drinks do you drink on weekdays? _____ drinks/day
- 2) On average, how many drinks do you drink on weekends? _____ drinks/day
- 3) Do you smoke? Yes No – If yes, how many cigarettes, pipes, or cigars/day?
- 4) For each of the following, please write in the average number that you drink each day:
Coffee _____ drinks/day; Tea _____ cups/day; soft drink _____/day

Prior medical conditions:

Please list prior surgeries: (include month/year if known)



Please list current medications with dosages:

_____	_____
_____	_____
_____	_____
_____	_____

List any allergy to medication or food or other: (Describe symptoms of allergy-rash, face swelling, anaphylaxis, throat swelling etc.) _____

Family history: Father alive? Yes No If not, what did he die of? _____
 Mother alive? Yes No If not, what did she die of? _____

****How likely are you to fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. 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

<i>Situation</i>	<i>Chance of Dozing</i>
Sitting and reading	
Watching TV	
Sitting, inactive, in a public place	
As a passenger in car for an hour	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
<i>Total Score</i>	