Patient's Name: ____________________________ Date: ________________

# BEFORE / AFTER

Circle One

**DO YOU HAVE ANY FAMILY MEMBERS WITH ANY OF THE FOLLOWING DISORDERS?**

| | YES | NO | MEMBER | | YES | NO | MEMBER |
|---|---|---|---|---|---|---|---|
| Trouble sleeping | ____ | ____ | ____________ | Choking during sleep | ____ | ____ | ____________ |
| Loud snoring | ____ | ____ | ____________ | Seizures and/or Epilepsy | ____ | ____ | ____________ |
| Obesity | ____ | ____ | ____________ | Thyroid gland disease | ____ | ____ | ____________ |
| Daytime sleepiness | ____ | ____ | ____________ | Restless legs at night | ____ | ____ | ____________ |
| Jerking legs at night | ____ | ____ | ____________ | High blood pressure | ____ | ____ | ____________ |

Has your spouse or bed partner commented on your sleep habits? YES_____ NO______
Please explain: ____________________________________________________________________________

## MEDICATIONS

DO YOU TAKE ANY SLEEPING PILLS? YES_____ NO_____ If YES, what ___________________

DO YOU TAKE ANY TRANQUILIZERS? YES_____ NO_____ If YES, what ___________________

DO YOU TAKE ANY STIMULATES? YES_____ NO_____ If YES, what ___________________

DO YOU USE NASAL DECONGESTANTS REGULARLY? YES_____ NO_____

DO YOU USE OVER THE COUNTER NASAL SPRAYS, ETC.? YES_____ NO_____

## CAFFEINE

APPROXIMATELY HOW MANY CUPS/CANS DO YOU DRINK PER DAY: COFFEE ______ ; TEA _____ ; COLA _______

## SOCIAL HISTORY

Did you experience any sleep related problems during schooling? YES______ NO______
SLEEP RELATED PROBLEMS AFFECT WORK ABILITY: YES____NO_____;
OCCUPATION:___________________________

# BEFORE / AFTER

Circle One

**DO YOU FIND THAT YOU:**

| | Never | Rarely | Sometimes | Usually |
|---|---|---|---|---|
| Sleep too long | ________ | ________ | ________ | ________ |

Are sleepy in the morning ________ ________ ________ ________
Have trouble waking up ________ ________ ________ ________
Feel rested in the morning ________ ________ ________ ________
Are sleepy during the day ________ ________ ________ ________
Take frequent naps ________ ________ ________ ________
Dream vividly during naps ________ ________ ________ ________
Feel refreshed after a nap ________ ________ ________ ________
Do things in order to stay awake ________ ________ ________ ________
Get enough sleep ________ ________ ________ ________
Have trouble falling asleep ________ ________ ________ ________
Lie awake with intense thoughts ________ ________ ________ ________
Wake up during the night ________ ________ ________ ________
Are a light sleeper ________ ________ ________ ________
Are a restless sleeper ________ ________ ________ ________
Are a heavy sleeper ________ ________ ________ ________
Awaken by physical problems ________ ________ ________ ________
Awaken with pain ________ ________ ________ ________
Awaken feeling tense ________ ________ ________ ________
Awaken feeling confused ________ ________ ________ ________
Walk in your sleep ________ ________ ________ ________
Talk in your sleep ________ ________ ________ ________
Grind you teeth in your sleep ________ ________ ________ ________
Have bladder problems at night ________ ________ ________ ________
Have bowel problems at night ________ ________ ________ ________
Twitch or jerk at night ________ ________ ________ ________
Kick your legs at night ________ ________ ________ ________
Awaken with bedding in a mess ________ ________ ________ ________
Snore heavily ________ ________ ________ ________
Have breathing problems at night ________ ________ ________ ________
Awaken choking or gasping ________ ________ ________ ________
Awaken with headaches ________ ________ ________ ________
Have palpitations at night ________ ________ ________ ________
Have chest pain at night ________ ________ ________ ________
Have bad dreams ________ ________ ________ ________
Dream about problems ________ ________ ________ ________
Use medications to help sleep ________ ________ ________ ________
Use alcohol to help sleep ________ ________ ________ ________
Drink caffeine before bed ________ ________ ________ ________
Sleep best on different time schedule ________ ________ ________ ________
Hear voices/see visions when asleep/awake ________ ________ ________ ________
Paralyzed upon awakening/falling asleep ________ ________ ________ ________
Sudden weakness when laughing or crying ________ ________ ________ ________
Do you stop breathing when you sleep ________ ________ ________ ________
Are kept awake by discomfort in your legs ________ ________ ________ ________

**ANY ADDITIONAL COMMENTS OR INFORMATION THAT HAS NOT BEEN COVERED**

________________________________________________________________________________

________________________________________________________________________________