Best Health Sleep Center

www.Bhscenter.com Fax: 866 324 3957, Tel: 866 938 9996

DATE:

Name:	Height:
Sex:	Weight :
Date of Birth:	Weight at age 20:
Age:	Marital status:
Refer Doctor:	BMI:
Phone:	Neck /Collar Size:

CHECK or CIRCLE as appropriate

- ◊ Have you ever been evaluated for sleep problem in the past? If yes give details. **Yes No**
- ◊ Have you ever been diagnosed with Sleep Apnea? Details **Yes No**

Do you currently use _____ CPAP (settings___), ___ home oxygen (liters/ flow __)

- ◊ What is the main reason you have been referred to the sleep disorder clinic?

___ Snoring ___ Sleepy during the day
____ Leg Jerks ___ Worries about my sleep
____ Other

How does your Sleep problem affect your life :

______ Affect quality of life _____Cause pain or discomfort.
______ Emotional impairments _____ Impair work performance.

Drug Allergy:

Home Medications (list): (Also list over the counter medications)

- ◊ Do you take any medication to help you sleep (**Yes No)**
- ◊ or to keep you awake (**Yes No)**

◊	◊
◊	◊
◊	◊
◊	◊
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PAST MEDICAL History (duration in years) ***CHECK as appropriate***

◊ High blood pressure	◊ Depression
◊ Angina / Heart attack	◊ Anxiety
◊ Heart Failure	◊ PTSD
◊ Irregular heart rhythm	◊
◊ High cholesterol	◊ Diabetes
◊	◊ Thyroid disease
◊ Asthma	◊ Reflux disease /Stomach ulcers
◊ COPD	◊ Seizure disorder
◊ Chronic bronchitis	◊ Stroke or TIA
◊ Chronic sinusitis, Nasal obstruction.	◊ Head injury
◊ Seasonal allergies	◊ Parkinson's disease
◊ Tonsillectomy, adenoidectomy	◊ Polio/ neurological weakness
◊ Nasal or sinus surgery	◊
◊ Sleep apnea	◊ Rheumatoid arthritis
◊ Insomnia	◊ Osteoarthritis
◊	◊ Fibromyalgia
◊	◊ Neck / Back pain
◊ Surgeries & other Medical problems	◊
◊	◊
◊	◊
◊	◊

SOCIAL HISTORY: (check as appropriate)

Never SMOKED: _________ Second hand smoking (years) ______

Former smoker (Quit date) __________

Prior smoking (Packs a day) _________ How many years you smoked_____

Current smoker : Average Packs a day __________ How many years __________

Other tobacco products used in a day: Cigars ______ Pipe ______Chewing Tobacco_____

Do you drink **ALCOHOL ?**

Never___ Social ____ Once a day_____ Alcohol before bedtime______ Excessive ________

Amount of **CAFFINATED** beverages you drink in a day ?

Tea (Cups)_____ Coffee (cups) ________ Cola (cans) ________ Chocolate ______

Please list any past or current **recreational DRUG USE** (Marijuana, Cocaine, etc) **Yes No**

OCCUPATION :

FAMILY HISTORY of major illness, sleep disorders, restless legs , cardiac disease, Diabetes.

Mother:

Father:

Siblings:

Other:

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Sleep Schedule:

1. Does your occupation include night shift work? **Yes** **No**
   If you do shift work, what is your sleep schedule?
2. Time you usually go to bed with intention to sleep.
   Week days (PM) Weekend and vacations (PM)
3. Time you usually get out of bed in the morning.
   On week days. (AM) On weekend and vacations.(AM)
4. How many hours do you think you sleep each night (average)?
5. How many times do you wake up each night (average)? 0 1 2 3 4 5
6. What wakes you up during the night?

☐ Going to rest room ☐ Cough ☐ Dry throat
☐ Nasal blockage ☐ Choking ☐ Shortness of breath
☐ Wheeze ☐ Palpitations ☐ Reflux
☐ Shortness of breath ☐ Noise
☐ Pain __ back pain other ________

Insomnia: *CHECK or CIRCLE as appropriate also list duration of problem in years.*

7. Does the following prevent you from falling asleep at night?

___Racing of mind / thoughts ___feel depressed or sad ___ frightened to sleep
___ noise, heat etc. _______

8. Once in bed does it take you more than half an hour to fall asleep? . . . . **Yes** **No**
9. Do you awaken much earlier in the morning and are unable to fall back to sleep? **Yes** **No**

Sleep Apnea: *CHECK or CIRCLE as appropriate also list duration of problem in years.*

10. Do you snore ☐ None ☐ Light ☐ Moderate ☐☐ Loud
    Duration in years.
11. If yes what makes it worse? __Sleeping on back __Fatigue __Sleeping on side __Alcohol
12. Do you stop breathing between snores /choke while asleep? **Yes** **No**
13. Do you gasp for breath in the middle of the night? **Yes** **No**
    If yes for how many years?
14. Do you breath through the **mouth** while asleep ? **Yes** **No**
15. Does snoring interrupt your spouse's/ partner's sleep ? **Yes** **No**
16. Sweating at night. **Yes** **No**
17. Restless or moving frequently while asleep. **Yes** **No**

Daytime sleepiness: ON WAKING UP WHICH OF THE FOLLOWING BEST DESCRIBES YOUR SLEEP?

18. Quality of sleep (poor) 1 2 3 4 5 (good)
    ☐ Light sleeper ☐ Deep sleeper
19. Feel **refreshed** and **rested** in the morning. Never Sometimes Always
20. Feel **tired** regardless of duration of sleep. Never Sometimes Always
21. Feel better in morning if I slept **more than seven** hours at night. Never Sometimes Always
22. During day time feel sleepy, want to sleep more. Never Sometimes Always
23. Last time you had a good night sleep . . . .
24. Morning Headache. **Yes** **No**
25. Daytime tiredness interferes with work, school, or relationships Never Sometimes Always
26. Trouble with ☐ Memory ☐ Concentration ☐ Focusing
27. While **driving** do you feel sleepy / tired ? **Yes** **No**

☐ Have pulled over to rest ☐ Accidents and Near misses due to sleepiness

28. **NAPPING:** Do you nap? **Yes** **No** (Actually falling asleep for more than five minutes).
    Number of days you nap : Week days ___ Weekends ___ Duration in minutes ____
    Time of the day you nap ____ Do you feel refreshed after the nap **Yes** **No**

Parasomnias: *CHECK or CIRCLE as appropriate*			*Duration in Years*
29. Talk while asleep.	**Yes**	**No**	
30. Walk while asleep.	**Yes**	**No**	
31. Nightmares or action filled dreams.	**Yes**	**No**	
32. Act out dreams.	**Yes**	**No**	
33. Have accidentally injured yourself or your partner.	**Yes**	**No**	
34. While asleep __ Grind teeth __Head Rocking __ Banging	**Yes**	**No**	
35. Do you wake up from sleep screaming, confused or violent?	**Yes**	**No**	
36. Do you have a problem with bed wetting?	**Yes**	**No**	
Restless Legs: *CHECK or CIRCLE as appropriate*			
37. While in bed (trying to sleep) do your legs have following __ itchy/hot, ___ crawling sensations __ leg cramps __ pains in calf ___ have the urge to move your legs	**Yes**	**No**	
38. Does this prevent you from falling asleep?	**Yes**	**No**	
39. Do your Legs kick or limbs twitch while asleep?	**Yes**	**No**	
Narcolepsy: *CHECK or CIRCLE as appropriate*			
40. Do you have difficulty concentrating at school or at work?	**Yes**	**No**	
When you are emotional (laughing, crying or angry) did you ever have following conditions? __ Knees buckle or feel weak __ body feels limp ___face sags?	**Yes**	**No**	
41. While falling asleep or upon awakening, (at night or during naps) have you experienced vivid dreams / hallucinations?	**Yes**	**No**	
42. Experience vivid dream-like scenes even though you are awake.	**Yes**	**No**	
43. No matter how hard you try to stay awake, do you still fall asleep?	**Yes**	**No**	
44. Have you woken up feeling paralyzed / unable to move ?	**Yes**	**No**	

Use the scale below and choose appropriate number.
0 = would never doze, 1 = slight chance of dozing, 2 = moderate chance of dozing, 3 = high chance of dozing

Situation	**Chance of dozing (0 to 3)**			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place i.e. a theater or meeting	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've had no alcohol)	0	1	2	3
In a car while stopped in traffic	0	1	2	3
TOTAL score	=			

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Do you have any of the following conditions? *CHECK or CIRCLE as appropriate*

Constitutional	Respiratory	Gastrointestinal
◊ Fatigue	◊ Shortness of breath	◊ Heartburn
◊ Night sweats	◊ Cough	◊ Abdominal pain
◊ Weight loss	◊ Wheeze	◊ Vomiting
◊ Weight gain in last two years		◊ Diarrhea
	Cardiac	◊ Constipation
	◊ Chest pain	◊
ENT	◊ Palpitation	Genitourinary
◊ Vision problems	◊ Leg swelling	◊ Blood in urine
◊ Hearing problems	◊ Dizziness	◊ Get up at night to urinate
◊ Nasal congestion		◊ Difficulty urination
◊ Post nasal drip	Musculoskeletal	◊ Heavy periods
CNS	◊ Back pain	◊ Sexual problems
◊ Headache	◊ Arthritis	◊
◊ Weakness / paralysis	◊ Pains in legs	
◊ Memory problems	◊ Aches and pains	◊
		◊
Psychiatric	Endocrine	◊
◊ Sad / crying spells	◊ Heat and cold intolerance	◊
◊ Anxiety	◊ Excessive thirst	◊
◊ Trouble concentration	◊	◊

- ◊
- ◊ Are you or your family having any problems adjusting to your disease or disability?
- ◊ Are you having any problems accepting limit of your physical problem?
- ◊ Do you follow a special diet which requires a need for education (i.e. diabetes)?
- ◊
- ◊

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Date

NAME:	Height:
	Weight:
	BMI :

When was CPAP therapy started				
CPAP machine pressure setting if known.	………….cm H2O,			
Heated humidifier				Yes NO
Mask type	__Full face	__ Nasal	__ Nasal pillow	
	__**S**mall	__ **M**edium	__ **L**arge	
Average hours of CPAP use every night ?	**3 – 4 hrs**	**6 – 7 hrs**	**8 or more hrs**	
Average days of CPAP use each week?	**0 1 2 3 4 5 6 7**	Days a week		
Do you benefit from use of CPAP ?	Yes	NO		
Snore while using CPAP.	__ None	__ Some times	__ Frequently	
Stop breathing while using CPAP	__ None	__ Some times	__ Frequently	
Wake up during night	__ None	__ Some times	__ Frequently	
Leg /limb twitching at night	__ None	__ Some times	__ Frequently	
Nasal congestion / Obstruction while using CPAP.	__ None	__ Some times	__ Frequently	
Sneezing and post nasal drip is a concern	__ None	__ Some times	__ Frequently	
Dry mouth or sore throat from using CPAP	__ None	__ Some times	__ Frequently	
Air Leak is a concern	__ None	__ Some times	__ Frequently	
Air irritating **eyes**	__ None	__ Some times	__ Frequently	
Trouble breathing with **too much pressure**	__ None	__ Some times	__ Frequently	
Have **claustrophobia**	__ None	__ Some times	__ Frequently	
Mask comes off the face during asleep	__ None	__ Some times	__ Frequently	
Redness or sore spots on nose or forehead.	__ None	__ Some times	__ Frequently	
Don't like **straps** around the head / cause **headache.**	__ None	__ Some times	__ Frequently	
Have Other problems with CPAP **mask**	__ None	__ Some times	__ Frequently	
Can't sleep well (CPAP use causes **Insomnia)** Fragmented / interrupted sleep	__ None	__ Some times	__ Frequently	
Palpitations during night	__ None	__ Some times	__ Frequently	
Aches and pains	__ None	__ Some times	__ Frequently	
Quality of sleep is.	__ Same	__ Better	__ Worse	
Feels refreshed next morning	__ None	__ Some times	__ Frequently	
Fatigue and sleepy during day time	__ None	__ Some times	__ Frequently	
Daytime naps	__ None	__ Some times	__ Frequently	
My energy level is	__ Same	__ Better	__ Worse	
Weight changes	◊ Same	◊ Lost . . . . . . lb	◊ Gained . . . . . . lb	
Abdominal distension	Yes	No		
Did you have cold or an other medical condition preventing regular use of CPAP describe.			Yes	No