

Patient's Name: _____

Date: _____

BEFORE / AFTER

Circle One

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

	<u>YES</u>	<u>NO</u>	<u>MEMBER</u>		<u>YES</u>	<u>NO</u>	<u>MEMBER</u>
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
