AlphaSleep labs

PATIENT DEMOGRAPHICS & SLEEP HISTORY

SECTION 1

Personal Information

Date: _____

Name: _____
Last First MI

Address: _____
Street City State Zip

Home Phone: _____ Cell: _____

Social Security #: _____ Date of Birth: _____

Age: _____ Sex: _____ Neck Size: _____ Height: _____ Weight: _____ lbs

Marital Status: _____ Employer/Occupation: _____

Referring Physician: _____ Office Phone: _____

Primary Care Physician: _____ Office Phone: _____

Please list allergies, if any: _____

Emergency Contact: _____
Name Relation Phone #

Insurance Information

Policy Holder / Guarantor Information: *(if different data than patient above)*	
Name:	Social Security #:
Relation to patient:	Birth Date:
Place of employment:	

Primary Insurance: _____ PH#: _____

ID #: _____ Policy Holder: _____

Secondary Insurance *(if applicable)*: _____ PH#: _____

ID #: _____ Policy Holder: _____

SECTION 2

Summary of Your Sleep Elements

1. Describe your sleep in your own words:

2. Describe HOW and WHEN this problem began:

3. Describe any treatments you have received for your problem:

4. Has this been a continuous or intermittent problem? *(Please mark which answer best applies)*
   - _____ **Continuous, almost every night**
   - _____ **Intermittent, occasional problem**
   - _____ **Frequent problem**

5. How long has your sleep problem been bothering you? *(Please choose one below)*
   - _____ **Longer than 2 years**
   - _____ **1 to 2 years**
   - _____ **Several the past 12 months**
   - _____ **within the last 3 months**
   - _____ **within the last month**

6. Please describe your sleep environment. (For example: How and where do you prefer to sleep, do you sleep alone or with a spouse or pet, etc., does your bed partner have sleep issues?)

SECTION 3

Medical History Conditions

1. Please list any chronic, present, or past medical illness diagnosed by a physician *(examples: COPD, Diabetes, Hypertension, Incontinent, etc.)*

_____

_____

_____

2. Please list the medications you take on a daily basis.

Medication	**Daily Dose**	**Reason**

3. Approximately how many ounces of the following beverages do you consume daily?

Natural coffee _____ **Colas with Caffeine** _____ **Chocolate** _____
Alcoholic drinks _____ **Decaf coffee** _____ **Tea** _____

4. Have you experienced a weight gain in the past year? ____ **Yes** ____**No**

   If so, how many pounds? _____ **lbs**

5. Do you have home oxygen? ____ **Yes** ____**No** If so, how many liters of oxygen per minute? _____**lpm**

   If yes, when do you wear it? ____ **continuously** or ____**just during sleep**

6. Do you have a home CPAP or BiPAP? ____ **Yes** ____**No** If yes, what is your pressure setting? _____**cm**

7. Have you ever smoked? ____ **Yes** ____**No**

   If yes, how many cigarettes/packs per day do/did you smoke? _____

   And if yes, how many years have you smoked? _____

   Do you smoke now? ____ **Yes** ____**No**

8. Do you drink alcohol? ____ **Yes** ____**No**

   If yes, estimate the number of drinks you have per day: _____ **on workdays**
   : _____**on days off**

9. What time do you normally go to bed? _____PM, **Workdays** _____PM, **Days off**

10. What time do you usually wake up? _____AM, **Workdays** _____AM, **Days off**

11. How long does it typically take you to fall asleep? _____

12. How many hours do you usually sleep each night? _____

13. How many times do you typically wake up at night? _____ Why? _____

    _____

14. If you wake up, how long do you stay awake before going back to sleep? _____

15. Which shift do you work? ____**Days** ____**Evenings** ____**Nights**

16. Do you ever rotate shifts? ____ **Yes** ____**No** If so, how often? _____

Please circle the appropriate response for each of the questions below using the following abbreviations:

N = Never, No **R = Rarely** **O = Occasionally** **F = Frequently** **A = Always**

17.	Do you feel refreshed after a short nap (1 hour or less)?	N R O F A
18.	Do you have heartburn or gas reflux problems during your sleep?	N R O F A
19.	Do you snore?	N R O F A
20.	Do you have nasal/sinus congestion at night?	N R O F A
21.	Do you have morning headaches?	N R O F A
22.	Are you a restless sleeper, tossing and turning at night?	N R O F A
23.	Do you wake thirsty with a dry mouth?	N R O F A

SECTION 4

Additional History

1. Do you have a family history of snoring or other sleeping disorders? ____ **Yes** ____**No**
   If yes, please describe in detail:

_____

_____

2. Do you breathe easily through your nasal passages? ____ **Yes** ____**No**
3. Are you unable to sleep in a flat position due to shortness of breath? ____ **Yes** ____**No**
4. Have you ever had a concussion, head injury, or blow to the head? ____ **Yes** ____**No**
5. Do you have spells, seizures, or passing out? ____ **Yes** ____**No**
6. Do you ever have or have you ever had high blood pressure? ____ **Yes** ____**No**
7. Do you drink after 6:00 PM? _____**Never** _____**On Occasion** _____**Frequently** _____**Always**
8. Do you consume caffeinated drinks? ____ **Yes** ____**No** *If yes, how many per day?* _____
9. Do you drink caffeine after 6:00 PM? _____**Never** _____**On Occasion** _____**Frequently** _____**Always**
10. Does the nature of your job require overnight travel? ____ **Yes** ____**No**
11. Are you able to fall asleep and then also awaken on a day-to-day / week-to-week basis according to your desired schedule? ____ **Yes** ____**No**
12. Do you nap during the day or during the evenings? ____ **Yes** ____**No**
13. Do you feel refreshed after a typical night's sleep? ____ **Yes** ____**No** *If not, please explain:*_____

_____

14. Do you feel sleepy during the day even when you have slept all night? ____ **Yes** ____**No**
15. Do you feel sleepy when driving? ____ **Yes** ____**No** *If yes, please cite specifics:*_____

_____

16. Have you had an accident or near accident while driving due to sleepiness? ____ **Yes** ____**No**
17. Do you fall asleep when you want to stay awake? ____ **Yes** ____**No**
18. Are you able to "fight off" excessive sleepiness in the situations noted in questions 14 - 17? ____ **Yes** ____**No**
19. Do you have memory or concentration problems? ____ **Yes** ____**No**
20. Do you experience vivid dream-like scenes upon awakening or falling asleep? ____ **Yes** ____**No**

21. When you are angry or laughing, do you ever feel weak or a lack of balance? _____ **Yes** _____**No**

22. Are you ever unable to move or speak upon falling asleep or awakening? _____ **Yes** _____**No**

23. Do you have trouble falling asleep when you first go to bed? _____ **Yes** _____**No**

24. When you try to fall asleep, does you mind race with many thoughts? _____ **Yes** _____**No**

25. When you try to fall asleep, do you wonder if you will be able to fall asleep? _____ **Yes** _____**No**

26. When you try to fall asleep, do you experience any pain? _____ **Yes** _____**No**

27. Does pain ever wake you, disrupt your sleep, or keep you awake? _____ **Yes** _____**No**

28. Are you a light sleeper who is easily awakened? _____ **Yes** _____**No**

29. Is your sleep disturbed because of your bed partner or others in the home? _____ **Yes** _____**No**

30. If you snore, does your snoring stop for brief periods during the night? _____ **Yes** _____**No**

31. Is your bed partner disturbed by your snoring? _____ **Yes** _____**No**

32. Do you use nasal strips, sprays, etc? _____ **Yes** _____**No**

33. Check any of the following that you feel apply to you:

□ **Nightmares**	□ **Palpitations**	□ **Feeling panicky**
□ **Unable to relax**	□ **Bowl Disturbances**	□ **Fainting**
□ **Headaches**	□ **Dizziness**	□ **Feeling Tense**
□ **Poor memory**	□ **Depression**	□ **Shyness**
□ **Difficulty with decisions**	□ **Insomnia**	□ **Bad Home Condition**
□ **Suicidal Ideas**	□ **Anxiety**	□ **Stomach Problems**

34. Please list any other information you would like for us to know about your sleeping problems.

_____

_____

35. If you sleep with a CPAP or BiPAP machine at night, what company provided your machine?

_____

36. If not, and following your studies there is a need for such equipment, do you have a preferred company you would want to use? _____

THANK YOU FOR YOUR TIME AND COOPERATION