NORTH DAKOTA Center for Sleep
A Division of PDS Inc.

AMERICAN ACADEMY OF SLEEP MEDICINE — WAKE SLEEP — MEMBER CENTER

Height: _____ Neck size: _____
Weight: _____ Weight 5 years ago: _____

## MEDICAL HISTORY

**Please check all that apply:**

Did you ever have?

□ Diabetes
□ High Blood Pressure
□ Asthma
□ Emphysema
□ Thyroid Disease
□ Kidney Disease
□ Stroke
□ Migraines
□ Heart Attack
□ Irregular Rhythm
□ Depression
□ Seizures
□ Gastric Reflux
□ Congestive Heart Failure
□ Fibromyalgia
□ Rhinitis/Sinusitis
□ Angina
□ Claustrophobia/Anxiety
□ Others: _____

## SURGICAL HISTORY

**Please list all surgeries, with dates:**

□ Tonsils/Adenoids
□ Sinus/Nasal Surgery
□ Heart Surgery
□ Heart Angiogram/Stents
□ Others: _____

## EPWORTH SLEEPINESS SCALE

**0 = NEVER doze off**
**1 = SLIGHT chance of dozing**
**2 = MODERATE chance of dozing**
**3 = HIGH chance of dozing**

| *Would you doze off while:* | *Scale Rating* |
|---|---|
| Sitting and Reading | _____ |
| Watching TV | _____ |
| Sitting inactive in public place | _____ |
| As a passenger in a car | _____ |
| Lying down to rest in the afternoon | _____ |
| Sitting and talking to someone | _____ |
| Sitting quietly after lunch without alcohol | _____ |
| In a car, while stopped in traffic | _____ |
| **TOTAL** | _____ |

## SOCIAL HISTORY

□ Single □ Married
□ Divorced □ Widowed

Do you have children? _____ How Old? _____

What kind of work? _____
I have a Commercial Driver's License
□ Yes □ No

## SOCIAL EXPOSURES

Did you ever smoke? □ Yes □ No
How many packs/day? _____
Started at what age? _____
When did you quit? _____

Do you drink alcohol? □ Yes □ No
How much? _____
What time of day? _____
Were you ever an alcoholic? □ Yes □ No

Do you consume caffeine? □ Yes □ No
□ Coffee □ Pop □ Energy Drinks
How much? _____

Did you use illicit substances? □ Yes □ No
□ Meth □ Marijuana □ Others: _____
How much? _____

## FAMILY HISTORY

My Mother is: □ Alive □ Deceased
What age? ____
Health problems: _____
_____

My Father is: □ Alive □ Deceased
What age? ____
Health problems: _____
_____

Any family history of:
□ Cancer □ Heart Disease □ Stroke
□ Seizures □ Sleep Apnea □ Insomnia
□ Others: _____

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## SLEEP HISTORY

**Please complete the following:**

What time do you go to bed? _____
On days off: _____

How long before you fall asleep? _____
_____

How many times do you wake up during the night?
_____

How many times do you go to the bathroom during the night? _____

What time do you get out of bed in the morning?
_____
On days off: _____

Use an Alarm Clock? □ Yes □ No

What time do you have to get to work?
_____

Do you nap? □ Yes □ No
How long? _____

Do you doze off? □ Yes □ No
What time of day? _____

Anyone share your bed? □ Yes □ No

Do you sleep better on vacation (away from home?)
□ Yes □ No
Please explain _____

Do you exercise? □ Yes □ No
What kind? _____
What time of day? _____

## ALLERGIES

Any Drug Allergies? □ Yes □ No
Please list: _____

## SLEEP HISTORY

**Please check all that apply:**

□ Driving accidents or near accidents due to sleepiness
□ Significant weight gain
□ Snore
□ Awaken with choking sensation

□ Trouble falling asleep
□ Trouble remaining asleep
□ Awaken with intense anxiety
□ Feel depressed during the day

□ Legs jerk and kick during sleep
□ Uncomfortable leg sensations that improve with movement
□ Uncomfortable leg sensations always worsening in the evenings

□ Jaw aches in the morning
□ Grind teeth in sleep
□ Sleep Talking as an adult
□ Sleep Walking as an adult
□ Acting out your dreams
□ Nighttime seizures
□ Shift Work

□ Awaken with back pain
□ Awaken with headaches
□ Awaken with heartburn or acid reflux
□ Awaken with cough or shortness of breath

□ Vivid dreams or hallucinations while awake
□ Paralysis or inability to move upon awakening
□ Sudden feeling of weakness in legs or knees

## MEDICATIONS

| Current Medication | Dose | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Use back if more space needed**