

Patient Name: _____

Date of Birth: ____/____/____

Primary Care Physician: _____

Referring Physician: _____

Past Medical History (PMS):

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergic Rhinitis	<input type="checkbox"/> TIA (transient ischemic attack)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Depression	<input type="checkbox"/> Deviated Nasal Septum	<input type="checkbox"/> Migraines
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Enlarged tonsils	<input type="checkbox"/> Headaches
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Seizures
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Restless Legs Syndrome
<input type="checkbox"/> COPD	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Suspected Dementia	<input type="checkbox"/> Sleep Apnea in the past <input type="checkbox"/> Using CPAP
<input type="checkbox"/> Using Oxygen	<input type="checkbox"/> GERD	<input type="checkbox"/> Stroke	<input type="checkbox"/> Sleep Apnea Surgery
<input type="checkbox"/> No Significant Medical History	<input type="checkbox"/> PTSD	<input type="checkbox"/> Testosterone deficiency	<input type="checkbox"/> Anemia

Hospitalizations & Surgeries (PSH):

No prior surgeries or procedures

Family History (Fam Hx):

Have any of your family members been diagnosed with the following? (Please check those that apply)

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Narcolepsy
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Restless Leg Syndrome
<input type="checkbox"/> Stroke or TIA	<input type="checkbox"/> Sleep Walking
<input type="checkbox"/> No Significant Family History	

Please list any additional family history below:

Mother: _____

Father: _____

Brother: _____

Sister: _____

Children: _____



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Social History (Social Hx):

Occupation: _____

Working hours: _____am/pm till _____am/pm

of hours you sit in traffic? _____

Level of Education (please check those that apply):

Grade School High School Vocational College Masters PhD MD/ DDS

Are you (please check those that apply):

Single Married Divorced Widowed Living with Significant Other

Caffeine & Alcohol consumption:

Coffee _____/day Hot chocolate _____/day

Soda _____/day Energy Drinks _____/day

Chocolate _____/day Tea _____/day

Alcohol (Beer, wine, liquor) _____/day

Tobacco (cigarettes, chewing, cigars):

Do you currently smoke? Yes No

If yes, how many per day? _____

When is your last cigarette at night? _____

Have you *ever* smoked? Yes No

If you no longer smoke, when did you quit? _____

Exercise:

Do you exercise routinely? Yes No

If yes please check each type you do:

Walking Jogging Running Sports Weight training Other _____

Are you often too tired to exercise? Yes No

Does most of your exercise come from your job? Yes No



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Allergies (please list all known allergies and *reaction*):

Environmental or Food Allergies:

No known environmental or food allergies

Drug allergies:

No known drug allergies

Medications:

Please list all medications (prescribed, over the counter and vitamins):

Medications	Dose	Frequency

Immunization History (Immun Hx):

Did you receive a flu vaccine (influenza) in the past year? Yes No

If yes, please list the date of vaccination: _____

Did you receive a Pneumonia shot (pneumococcal polysaccharide vaccine)? Yes No

If yes, please list the date of vaccination: _____



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Sleep Questionnaire:

<input type="checkbox"/> I have been told I snore	<input type="checkbox"/> Frequent urination at night	<input type="checkbox"/> I sometimes feel paralyzed just when I wake up or fall asleep
<input type="checkbox"/> Pauses in breathing	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Falling out of bed
<input type="checkbox"/> Snorting	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Sleep walking
<input type="checkbox"/> Wake up choking or short of breath	<input type="checkbox"/> Un-refreshed upon awakening	<input type="checkbox"/> Nightmares
<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Daytime Sleepiness	<input type="checkbox"/> I have experienced vivid hallucinations upon going to sleep or awakening
<input type="checkbox"/> Difficulty falling asleep	<input type="checkbox"/> Fall asleep at unpredictable times	<input type="checkbox"/> Sleep talking
<input type="checkbox"/> Wake up at night; have trouble falling back to sleep	<input type="checkbox"/> Fatigue/tiredness	<input type="checkbox"/> Screaming at night during sleep
<input type="checkbox"/> Clock watching	<input type="checkbox"/> Frequent refreshing naps	<input type="checkbox"/> Night Terrors
<input type="checkbox"/> Frequent awakenings	<input type="checkbox"/> Frequent un-refreshing naps	<input type="checkbox"/> Acting out dreams
<input type="checkbox"/> Waking up too early on most mornings	<input type="checkbox"/> Sleep problems interfere with my life (work, social)	<input type="checkbox"/> Loss of muscle tone with laughter or anger or other emotions (cataplexy)
Significant weight change recently? Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Gain <input type="checkbox"/> Loss	<input type="checkbox"/> Teeth grinding If yes do you wear a Mouth Guard? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Waking up in the middle of the night with confusion or disoriented (confusional arousal)
<input type="checkbox"/> Morning headaches	<input type="checkbox"/> I eat in my sleep	<input type="checkbox"/> I have racing thoughts that prevent me from sleeping

Routine Sleeping Habits:

My bedtime: From _____ am/pm to _____ am/pm;

Weekends: From _____ am/pm to _____ am/pm

How long does it take you to fall asleep? _____ min/hours

Does your partner snore? Yes No

Is your bedroom environment? **Dark** Yes No **Quiet** Yes No **Comfortable temperature** Yes No

Do you frequently have children or pets in the bed? Yes No

When do you sleep better (Check which one best applies to you): Weekdays Weekends Vacation

Do you do any of the following in bed:

Watch Television Yes No Video Games Yes No

Computer Yes No Cell Phone/ Text Yes No

Restless Legs Symptoms:

Do you have an urge to move your legs when you are sitting or lying? Yes No

If yes, are they worse during evening/ night? Yes No

Are they relieved by movement (stretching, getting-up)? Yes No

Does a bed partner report kicking/sheets in disarray? Yes No



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EPWORTH SLEEPINESS SCALE:

This scale refers to your usual way of life in recent times. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation.

SCALE:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Sitting and reading Situation/Activity Chance of Dozing:	Scale
Sitting and reading	
Watching TV	
Sitting, inactive in a public place such as a theater or meeting	
As a passenger in a car for an hour without a break	
Lying down resting in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total score (add all responses)	

Height: _____ Weight: _____ Neck Circumference: _____

Are you worried or do you have any concerns about sleeping in the sleep center?

Not at all Slightly Moderately Very much

We want you to be very comfortable. What are your concerns?

Sign: _____ Date: _____



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