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Vista Sleep CENTER

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PHONE: (509)987-1246 FAX: (509)987-1247

Patient Name: _____

Date of Birth: _____

****PLEASE COMPLETE AND BRING PACKET TO YOUR APPTOINTMENT ON:**

PATIENT HISTORY (Please answer these questions with your bed partner, if possible)

Reason you were referred and / or desire a sleep evaluation:

_____

_____

_____

Do you have a bed partner? ☐ Yes ☐ No

How long have you had issues with your sleep? _____ Months/Years

Do you have any other issues with your sleep not previously listed?

_____

_____

Epworth Sleepiness Scale

The ESS (Epworth Sleepiness Scale) is another tool we use to measure a person's general level of daytime sleepiness.

The test is a simple, eight-question survey.

Simply write the score on the line provided and return it to your doctor.

How likely are you to fall asleep or doze off in the following situations?

Use the following scale to choose the most appropriate number for each situation:

0- Would never doze
1- Slight chance of dozing
2- Moderate chance of dozing
3- High chance of dozing

1. Sitting and reading.

2. Watching T.V

3. Sitting, inactive in a public place (Theater, Meeting).

4. Sitting as a passenger in a car for an hour without a break.

5. Lying down to rest in the afternoon when the circumstances permit.

6. Sitting and talking to someone.

7. Sitting quietly after a lunch without alcohol.

8. In a car, while stopped for a few minutes in traffic.

Total Score:_____

Scoring your results:

A total score of 10 or more suggests that you may need further evaluation by a physician to determine the cause of your excessive sleepiness and whether you have an underlying sleep disorder

Sleep History:

Have you ever had a sleep study?	□ Yes	□ No
If yes, did it show you had sleep apnea? (Please bring copy if possible)	□ Yes	□ No
When you relax in bed or watch TV, do your legs feel restless and jittery?	□ Yes	□ No
Do you snore loudly?	□ Yes	□ No
Does your bed partner complain about your snoring?	□ Yes	□ No
Does your snoring wake you up at night?	□ Yes	□ No
Do you or your bed partner notice that you make gasping or choking noises during sleep?	□ Yes	□ No
Do you have a dry mouth, sore throat or headache in the morning?	□ Yes	□ No
Do you have high blood pressure?	□ Yes	□ No
Do you have frequent nightmares?	□ Yes	□ No
Have you been diagnosed with Restless Leg Syndrome?	□ Yes	□ No
Do you sleep walk or have unusual behaviors while asleep?	□ Yes	□ No

Please check any of the restless leg syndrome symptoms you experience:

□ Urge to move legs associated with unpleasant sensation.

□ Worsening of symptoms with rest.

□ Improvement of symptoms with movement or getting up.

□ Symptoms tend to increase in the evening and night.

How do you feel when you wake up in the morning?

_____

_____

Sleep Schedule:

What time do you go to bed on a work day? _____ □ AM □ PM

What time do you get up on a work day? _____ □ AM □ PM

What time do you go to bed on a non-work day? _____ □ AM □ PM

What time do you get up on a non-work day? _____ □ AM □ PM

How many hours do you sleep on a non-work day? _____ □ AM □ PM

Sleep Hygiene:

Do you awaken feeling refreshed? □ Yes □ No

Is your sleep/ wake schedule regular? □ Yes □ No

Do you take naps? □ Yes □ No

If so, how many times per day and how long? _____

Do you feel refreshed after your naps? □ Yes □ No

Do you read in bed? □ Yes □ No

Do you watch TV in bed? □ Yes □ No

Are you currently a shift worker? □ Yes □ No

Have you done shift work in the past? □ Yes □ No

If so, how long did you do shift work? _____

Insomnia:

Do you have trouble going to sleep at your bedtime? □ Yes □ No

How long does it take for you to fall asleep at bedtime? _____

Do you awaken during your sleep time? □ Yes □ No

How many times per night do you awaken? _____

Why do you awaken?_____

Do you have long periods when you awaken and are unable to get back to sleep? ☐ Yes ☐ No

Are you bothered by waking up too early and not being able to get back to sleep? ☐ Yes ☐ No

How many times a week do you feel you have a sleep problem? #_____

Movements:

Is your bed a mess in the morning? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

If so, how often? _____ Per week

Parasomnias:

As a child, did you have a sleep problem? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Excessive Sleepiness:

Are you excessively sleepy in the daytime? ☐ Yes ☐ No

If yes, how long? _____ Yrs _____ Mths

Are you currently using oxygen, C- PAP or an oral appliance? ☐ Yes ☐ No

Have you had airway surgery for obstructive sleep apnea? ☐ Yes ☐ No

What else have you tried for your sleep problems?

_____

Have you had an accident or near-miss accident because of falling asleep driving? ☐ Yes ☐ No

Have you had sudden muscle weakness when you laugh, angry or surprised? □ Yes □ No

Have you felt your body paralysis when waking up? □ Yes □ No

Do you have vivid dreams when you are falling asleep or just waking up? □ Yes □ No

Have you been told that you stop breathing during sleep? □ Yes □ No

Do you wake with headaches? □ Yes □ No

If yes, how often? _____ Nights per week

Do you have night sweats? □ Never □ Weekly □ Nightly

Do you have trouble with sexual function? □Never □ Nightly

How often do you snore? _____ Nights per week

Does sleep position change your snoring? □ Yes □ No

Do you have difficulty breathing through your nose? □ Yes □ No

Weight History:

Weight at age 20: _____ lbs.

Current weight: _____ lbs.

Have you attempted to diet? □ Yes □ No

What is your maximum weight loss? _____ Lbs.

Can you keep the weight off? □ Yes □ No

Have you ever had any of the following symptoms or situations?

□ Waking up to eat or drink at night?

□ Panic attacks at night?

□ Recurrent frightening dreams?

□ Sleep waking, talking, yelling, screaming or kicking?

□ Sudden muscle weakness caused by emotion or stress?

☐ Unable to move body while waking up or falling asleep?

☐ Hallucinations or dreams while going to sleep or waking?

Men Only:

Have you had problems with erectile dysfunction? ☐ Yes ☐ No

Have you had problems awakening with painful erections? ☐ Yes ☐ No

Women Only:

Are you awakened by painful menstrual cramps? ☐ Yes ☐ No

Do you sleep problems occur at the time of your menstrual cycle? ☐ Yes ☐ No

Do your sleep problems begin at the time of menopause? ☐ Yes ☐ No

Are you currently taking birth control pills? ☐ Yes ☐ No

Are you currently on estrogen supplementation? ☐ Yes ☐ No

Family History:

Have any of your family members had any of the following?

☐ Obstructive Sleep Apnea

☐ Loud Snoring

☐ Excessive Sleepiness

☐ Insomnia

☐ Narcolepsy

☐ Depression

☐ Anxiety

☐ Heart Disease

☐ Epilepsy or Seizure Disorder

☐ Parkinson's disease

□ Attention Deficit Disorder

□ Hyperactivity

□ Other: _____

Do you have children? □ Yes □ No

Ages and Sexes of children:

_____

_____

Do you have stress at work? □ Yes □ No

Do you have stress at home? □ Yes □ No

Social History:

Have you ever smoked? □ Yes □ No

Do you currently smoke? □ Yes □ No

Do you smoke cigars, a pipe, or use chewing tobacco? □ Yes □ No

Do you currently use caffeine? □ Yes □ No

If yes, how much do you consume? _____cups/oz. _____ per day.

Do you smoke marijuana or use other illegal drugs? □ Yes □ No

Do you currently use alcohol? □ Yes □ No

On average, how many alcoholic beverages do you consume on a weekday? ____ # _____ times per week

On average, how many alcoholic beverages do you consume in a weekend? ____ #

Have you ever felt annoyed by others when they express concern about your alcohol consumption?

□ Yes □ No

Have you ever felt guilty about your drinking? □ Yes □ No

Do you ever drink just before going to bed? □ Yes □ No

Psychological History:

Do you feel depressed? ☐ Never ☐ Rarely ☐Occasionally ☐ Frequently

Do you feel depressed now? ☐ Yes ☐ No

Have you had a personality change? ☐ Yes ☐ No

Have you ever been evaluated by a psychiatrist or any other mental health provider? ☐ Yes ☐ No

Are you currently being evaluated by a mental health provider? ☐ Yes ☐ No

Medical Diagnosis:

Diagnosis	Month/Year Diagnosed	Doctor

Medication List:

Name of Medication	Strength	Directions of use (2x's daily, 3x daily, at dinner, ect.)

Allergies:

Item/ Medication	Reaction

Surgeries: (In the last 4 years or recent future)

Name	Month/ Year	Doctor

Additional Comments/ Information:

_____

_____