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Capitol Area Pulmonary Associates

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SLEEP CONSULTATION -NEW PATIENT

- Patient Name: _____
- Patient DOB: _____
- Patient INSURANCE: _____

- Address: Street: City: State: Zip:
- Home Phone Number: Cell Phone Number:
- Age: ____Sex: Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Separated
- Race: ☐ Caucasian (White) ☐ African American ☐ Asian ☐ Hispanic ☐ Native American ☐ Other:
- Occupation:
- Height: Weight: Neck Circumference:
- Has there been any recent weight gain or loss? ☐Yes ☐ No If Yes, a gain of: or a loss of: lbs.
- Over how many months has this weight gain or loss occurred?
- Healthcare Professional who referred you to us (Doctor, Physician's Assistant or Nurse Practitioner, Other):

- **Your main complaint(s):** ☐Snoring ☐ My breathing stops ☐ I am sleepy ☐ I talk or walk in my sleep ☐ I can't fall asleep
  - Other (please comment):
- How long have you had this problem? About ☐ months ☐ years
- How has this problem affected your life?

SLEEP SCHEDULE :

- What time do you go to bed?
- WEEKDAYS? _____ ☐AM ☐ PM, WEEKENDS? _____ ☐AM ☐ PM
- What time do you wake up on WEEKDAYS? _____ ☐AM ☐ PM, WEEKENDS? _____ ☐AM ☐ PM
- Do you nap? ☐ Yes ☐ No, how often do you nap? _____ Times per week.
- How long are the naps? _____ Do you awaken refreshed? ☐ Yes ☐ No
- Are you a shift worker? If yes, what times do you work? _____

SNORING / BREATHING HISTORY :

- Do you snore? ☐ Yes ☐ No
- Does your sleep position affect your snoring? ☐ Yes ☐ No
- Have you awakened from choking or short of breath? ☐ Yes ☐ No
- Has anyone noticed that you stop breathing while asleep? ☐ Yes ☐ No
- Do you have morning headaches? ☐ Yes ☐ No
- Do you awaken more than twice to urinate during the night? ☐ Yes ☐ No
- Do you awaken refreshed in the morning ☐ Yes ☐ No

- Do you awaken with an acid or sour taste in your mouth ☐ Yes ☐ No
- Do you have difficulty sleeping on your back? ☐ Yes ☐ No

SLEEP HISTORY

- Do you have difficulty falling asleep? ☐ Yes ☐ No
- Do you have difficulty staying asleep? ☐ Yes ☐ No
- Do you wake up too early and cannot get back to sleep? ☐ Yes ☐ No
- Do you have thoughts racing through your mind that make it difficult to sleep? ☐ Yes ☐ No
- Have you fallen asleep unexpectedly? ☐ Yes ☐ No
- Have you ever fallen asleep while driving drowsy? ☐ Yes ☐ No
- Have you ever had a motor vehicular crash due to drowsy driving? ☐ Yes ☐ No
- Have you experienced "sleep attacks" (a sudden irresistible urge to sleep)? ☐ Yes ☐ No
- Have you experienced sudden muscle weakness in response to emotions ☐ Yes ☐ No
- Have you experienced an inability to move while falling asleep or waking up? ☐ Yes ☐ No
- Have you experienced dreamlike images or sounds while falling asleep or waking up? ☐ Yes ☐ No
- Do you kick or jerk your arms or legs during sleep? ☐ Yes ☐ No
- Have you experienced an urge to move your legs accompanied by an uncomfortable ☐ Yes ☐ No
- Sensation? ☐ Yes ☐ No
- Do you have an urge to move your legs that worsens with rest or inactivity like lying down or sitting? ☐ Yes ☐ No
- Do you have an urge to move your legs that is relieved by walking or stretching? ☐ Yes ☐ No
- Do you have an urge to move and an unpleasant sensation in your legs that occurs only at night? ☐ Yes ☐ No
- Do you talk in your sleep? ☐ Yes ☐ No
- Do you have nightmares? ☐ Yes ☐ No
- Have you ever acted out your dreams? ☐ Yes ☐ No
- Do you grind your teeth? ☐ Yes ☐ No

MEDICAL/SURGICAL HISTORY

- Have you ever had a sleep study in the pas ☐ Yes ☐ No When? Where? _____
- Do you use home CPAP or BIPAP? ☐ Yes ☐ No What pressure setting? _____
- Do you use home oxygen? ☐ Yes ☐ No
- Have you ever had a tonsillectomy? ☐ Yes ☐ No
- Have you ever had sinus or nasal surgery? ☐ Yes ☐ No
- Have you ever had any type of head injury? ☐ Yes ☐ No
- Have you had surgery to promote weight loss? ☐ Yes ☐ No When? _____
- ☐ Hypertension ☐ Acid Reflux (heartburn) ☐ Heart Attack ☐ Arthritis
- ☐ Sexual dysfunction/ loss of libido ☐ Cardiac Arrhythmias ☐ Diabetes ☐ Depression
- ☐ Lung problems/ COPD/Asthma ☐ Anxiety ☐ Seizures ☐ Claustrophobia
- ☐ Congestive Heart Failure ☐ Fibromyalgia ☐ Dementia ☐ Stroke/ TIA

  Other_____

FAMILY HISTORY (Does any member of your family have the following?)

- Sleep Apnea? ☐ Yes ☐ No Relationship _____
- Narcolepsy? ☐ Yes ☐ No Relationship _____

SOCIAL HISTORY (please circle answer and fill in the blank where appropriate)

- What is your occupation? _____If retired when? _____
- Do you smoke? ☐ Yes ☐ No Packs per day? _____ how long? _____
- Have you smoked in the past? ☐ Yes ☐ No Packs per day? _____ how long? _____ If you quit, when?_____
- Do you drink beer, wine, or liquor? ☐ Yes ☐ No How much? _____ How long? _____

REVIEW OF SYSTEMS (Please check where appropriate if you have had any of these symptoms in the last 12 months).

- Frequent headaches ☐ Yes ☐ No
- Urinating more than 2x a night ☐ Yes ☐ No
- Difficulty understanding instructions ☐ Yes ☐ No
- Decreased short term memory ☐ Yes ☐ No
- Difficulty organizing thoughts ☐ Yes ☐ No
- Difficulty planning activities/trips ☐ Yes ☐ No

Irregular heartbeat ☐ Yes ☐ No
Shortness of breath/wheezing ☐ Yes ☐ No
Pain in bones or joints ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No
Weight loss of more than 5-10 ☐ Yes ☐ No
Others (Describe) _____

MEDICATIONS (please list, attach a separate sheet if necessary)

Medication	Dose	# Times/Day	Medication	Dose	#Times/Day

Allergies (please list) ____ ☐NO KNOWN DRUG ALLERGIES

_____

_____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Please circle the most appropriate answer using the following scale.

0 = never	1 = occasionally	2 = often	3 = usually

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
At a public place like a theater or meeting	0	1	2	3
While a passenger in a car for one hour or more	0	1	2	3
Lying down in the afternoon	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting down after lunch	0	1	2	3
Stopped at a stoplight	0	1	2	3

Total score out of 24: _____(please add)