Patient Medical History
2665 North Decatur Rd, Suite 435 Decatur, GA 30033
Phone: 404-501-5927 Fax: 404-501-7088

Name: _____**Date**: _____ **Gender**: M F
SS# ___ __ ____

Marital Status: M S D W **DOB:** _____ email addr: _____

Emergency Contact: _____

My MAIN sleep problem has bothered me:

__ longer than 2 years **__ several months to 12 months**
__ 1 to2 years **__ within the last 3 months** **__ within 1 month**

If previously diagnosed with a sleep disorder please indicate and prescribed treatment:
Previously diagnosed with:
____ Sleep apnea **____ RLS/Periodic Limb Movements** **____ Narcolepsy** **____ Insomnia**
When ____ Where _____
Treatment:
_____
_____

SLEEP SYMPTOMS: Please check the following symptoms that APPLY

	Symptom
	Awaken with a dry mouth
	Morning headaches
	My mind races with many thoughts when I try to fall asleep
	Snoring
	Fatigue
	Anxiety
	Memory impairment
	Inability to concentrate
	Irritability
	Depression
	Suicidal thoughts
	Pain which delays or prevents my sleep
	Pain which awakens me from sleep

	Vivid or lifelike visions (people in the room, etc) as you fall asleep or awaken
	Awaken gasping for air
	Sudden weakness or feel your body go limp when you are angry or excited
	Inability to move as you are trying to go to sleep or wake up
	Unpleasant leg sensation causing irresistible urge to move legs or arms
	Creeping or crawling sensation in your legs before falling asleep
	Legs or arms jerking during sleep
	Sleep talking
	Sleep walking
	Nightmares
	Fall out of bed
	Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep
	Bed wetting
	Frequent urination disrupting sleep
	Teeth grinding
	Wheezing or cough disrupting sleep
	Sinus trouble, nasal congestion or post-nasal drip interfering with sleep
	Shortness of breath disrupting sleep

MEDICAL HISTORY

Please check if you have had any of the following:

	Hepatitis		High Cholesterol		Diabetes
	High blood pressure		Intestinal Disease		Thyroid Condition
	Irregular heartbeat		Reflux		Venereal disease
	Heart Attack		Ulcer		HIV
	Heart Failure		Head Injury		Blood clot
	TB		Parkinson's disease		Anemia
	Chronic Bronchitis		Glaucoma		Arthritis
	Pneumonia		Kidney/Bladder		Gallbladder problems
	Sarcoidosis		Stroke		Fibromyalgia
	Asthma/Emphysema		Rheumatic Fever		Cancer
	Sinusitis		Other:		

FAMILY HISTORY: *(Please check all that apply)*

	Apnea	Snoring	Narcolepsy	Diabetes	Stroke	Cancer	Heart Disease	Deceased	Age?
Mother									
Father									
Sister(s)									
Brother(s)									
Grandparent(s)									

BMI

What do you weigh now? _____ What is your height? _____

What was your weight? 1 year ago _____ 5 years ago _____
Neck size? Current _____ 1 year ago _____

SOCIAL HISTORY

Do you smoke now? Y/N Previously smoke? Y/N
How much per day? _____ Do you drink alcohol? Y/N How much?
_____ per day
How much caffeinated coffee, tea or cola do you drink daily? _____
I am currently working: Y/N Retired____ Disabled____

SLEEP HABITS

Please answer the following questions as accurately as possible. Indicate AM and PM.

Activity	**Your bedtime schedule**
Time you enter bed and turn off the lights	
I usually fall asleep in (minutes, hours)	
How often do you awaken each night?	
Number of times you have difficulty returning to sleep	
The total time I spend awake in bed	
What time do you usually get out of bed from sleep?	
How many daily hours sleep do you usually get?	
Begin work time/end work time	
Indicate total length of naps daily	

If you do rotating shift work, or have other work schedule changes and need more space to describe:

_____
_____
_____

List all Medications: (or provide typed sheet)

NAME **DOSAGE**
FREQUENCY

Allergies?:

PLEASE CHECK ANY SYMPTOMS PRESENT IN LAST TWO WEEKS

	Constitutional		**Gastrointestinal**		**Neurological**
	Change in weight		Nausea / vomiting		Freq. / severe Headaches
	Fever / chills / night sweats		Vomiting blood		Numbness or tingling
	Respiratory		Trouble Swallowing		Incoordination / recent falling
	Short of breath		Indegestion or Heartburn		Weakness in legs and arms
	Coughing / Asthma / wheezing		Abdominal Pain/Swelling		**Skin**
			Bloody or Dark Stools		Itching / rash / skin lesions
	Coughing up blood		Diarrhea/Constipation		Changes in a mole
					Breast Pain /Lump
	Cardiac		**Genitourinary**		**Endocrine**
	Chest pain / discomfort		Problems voiding / urinating		Heat/Cold Intolerance
	Short of breath when reclining		**Musculoskeletal**		Excessive Thirst Urination
	Fast pulse / irregular heart / Palpitations		Arthritis / Joint Swelling /Aches		**Hematological**
	Wake up short of breath		Back / rib cage / chest wall pain		History of blood clot
	Black out spells / fainting /		Joint Stiffness		Enlarged lymph nodes
	Leg / ankle swelling		Paralysis/Limb Weakness		Excessive bruising / bleeding
	Eyes, Ears, Nose & Throat				**Psychiatric**
	Hearing difficulty / ringing in ears		Sore throat / hoarseness / throat pain		Unusual anxiety / depression
	Sinus / nasal / cold symptoms		Changes in vision / double vision		Drug / alcohol addiction

TAKE THE SLEEPINESS TEST

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. 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.

0= would never doze **2= moderate chance of dozing**
1= slight chance of dozing **3= high chance of dozing**

Situation
Chance of dozing

Sitting and reading……
0 1 2 3

Watching TV……
0 1 2 3

Sitting, inactive, in a public place (e.g. a theatre or a meeting)
0 1 2 3

As a passenger in a car for an hour without a break ……
0 1 2 3

Lying down to rest in the afternoon when circumstances permit
0 1 2 3

Sitting and talking with someone……
0 1 2 3

Sitting quietly after a lunch without alcohol……
0 1 2 3

In a car, while stopped for a few minutes in traffic…….
0 1 2 3

TOTAL _____

Sleep Diary

Please complete a diary of your typical sleep pattern for the two (2) days before to your study. Each column represents one day. Indicate in each column the requested information.

	Day One	Day Two
Date		
Lights Out		
Time it took to fall asleep		
Number of awakenings		
Total time awake		
Lights On		
Nap Time During the Day		
Total Time Asleep		

Comments:

_____

_____

_____

_____