Sleep 360 Sleep Diagnostic Center

Complete solution to your sleep problems

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Patient Sleep History

Name: ----------Sex--------DOB: ----------Date: ----------

Height: ---------- Weight (lbs): ---------- Neck/collar Size (inches): --------

Describe in detail your sleep problem and how long has this been a problem: ----------
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What time do you typically go to bed and get up?
Weekdays Bedtime ---------- Wake Time ----------
Weekends Bedtime ---------- Wake Time ----------
When you wake up in morning do you feel refreshed? ----------Yes ---------No
How long does it usually take you to fall asleep once the lights are turned off? ----------
Do you awaken during night? ----------Yes ----------No
How many times? --------1 time -------2-3 times --------4-5 times -------more
How long does it take you to return to sleep upon these awakenings? ----------
Do you take naps during the day? -------Yes-----No.
If yes, how often? ---------- Average length of a nap: ----------
Do you feel refreshed after you awaken from these naps? ---------Yes ----------No
Note the positions you normally sleep in: ----Back -----Right ------Left -----Stomach
Have you been under the care of a cardiologist? ----------Yes ---------No

Do you snore? ---------Yes ----------No ----------Sometimes
Rate your snoring: ------- I do not snore -------Mild ------Moderate ------Loud
Do you hold your breath or stop breathing in your sleep? ---Yes ---No ---Sometimes
Do you wake up with choking sensation or out of breath? ---Yes ---No ----Sometimes
Do you have heartburn, indigestion or feel bloated at night? ----Yes---No---Sometimes
Do you have night sweats? ---------Yes ----------No ----------Sometimes
Do you wake up with a headache? ---------Yes ----------No ----------Sometimes
Do you awaken with a dry mouth? ---------Yes ----------No ----------Sometimes
Do you feel sleepy during the day? ---------Yes ----------No --------Sometimes
Do you feel fatigue/tired during the day? --------Yes ----------No ----------Sometimes
Do you fight sleep while driving? ---------Yes ----------No ----------Sometimes
Did you have a car wreck caused by sleepiness? ---------Yes ----------No
Do you have problems with memory or concentration? ----Yes ----No -----Sometimes
Do you have impotence or lack of sex drive? ------Yes --------No --------Sometimes
Change in personality? -----Yes ------No
Have you had a recent weight gain? ---------- If yes, how much? ----------
Have you had a recent weight loss? ---------- If yes, how much? ----------

When you awaken from sleep, do you feel paralyzed unable to move?
---------Yes ----------No ----------Sometimes

When someone startles you or makes you laugh, do you get weak/lose strength?
---------Yes ----------No ----------Sometimes
While in the process of falling asleep, do you have vivid dreams or hallucinations?
---------Yes ----------No ----------Sometimes
Do you have frequent uncontrollable bouts of sleep /sleep attacks during the day?
---------Yes ----------No ----------Sometimes
Do you grind teeth at night? ---------Yes ----------No ----------Sometimes
Have you been told that your legs twitch/move frequently in sleep?
---------Yes ----------No ----------Sometimes
Do you experience creepy, crawly, aching, burning sensation in legs, arms or body while awake or relaxing? ---------Yes ----------No ----------Sometimes
If yes, does it give you strong urge to move? ------Yes -------No
Does it get better with movement? -------Yes --------No

Do you feel irritable/depressed/anxious? ---------Yes ----------No ----------Sometimes
Do you have difficulty falling asleep or maintaining sleep? ----Yes----No------Sometimes
Do you have racing thoughts that prevent you from sleeping? ----Yes---No-----Sometimes

I talk in my sleep ----------Yes ----------No
I walk in my sleep ---------Yes ----------No
I eat in my sleep ----------Yes ----------No
Do you act out in your dreams? ----------Yes ----------No
Do you have frequent nightmares? ----------Yes ----------No

Sleep Environment

Do you have a bed partner? -------No ------- Yes
Does your bed partner disturb your sleep? ------ No ------- Yes If so, how?

Do you disturb sleep of your bed partner? ------ No ------- Yes If so, how?

Do you have pets in your bedroom? ----------No ----------Yes
Do you use an alarm clock to wake up? -------- No --------- Yes
Is your bedroom temperature cool and condusive to sleep? ---------- No ---------- Yes
Is your mattress comfortable? ------- No --------- Yes
Do you work / read/ watch TV/ work on computer in bedroom? ----------

Epworth Sleepiness Scale

Please rate the chances of dozing in the following situations:

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

Sitting and reading ----------
Watching TV ----------
Sitting inactive in a public place (e.g.; theater or meeting) ----------
As a passenger in a car for an hour without a break ----------
Lying down to rest in afternoon ----------
Sitting and talking to someone ----------

Sitting quietly after lunch without alcohol ----------
In a car, while stopped in traffic ----------
Total score ----------

Berlin Questionnaire

1. Do you snore
   ----- Yes
   ----- No
   ----- Don't Know

2. Your snoring is?
   ----- Louder than talking
   ----- Very Loud. Can be heard in adjacent rooms
   ----- Slightly louder than breathing
   ----- As loud as talking

3. How often do you snore?
   ---- Nearly every day
   ---- 3-4 times a week
   ---- 1-2 times a week
   ---- 1-2 times a month
   ---- Never or nearly never

4. Has your snoring ever bothered other people?
   ---- Yes
   ---- No

5. Has anyone noticed that you quit breathing during your sleep?
   ---- Nearly every day
   ---- 3-4 times a day
   ---- 1-2 times a week
   ---- 1-2 times a month
   ---- Never or nearly never

6. How often do you feel tired or fatigued after your sleep?
   ---- Nearly every day
   ----3-4 times a week
   ----1-2 times a week
   ----1-2 times a month
   ---- Never or nearly never

7. During your wake time, do you feel tired, fatigued or not up to par?
   ---- Nearly every day
   ---- 3-4 times a week
   ---- 1-2 times a week

---- 1-2 times a month
---- Never or nearly never

8. Have you ever nodded off or fallen asleep while driving a vehicle?
   ---- Nearly every day
   ---- 3-4 times a week
   ---- 1-2 times a week
   ---- 1-2 times a month
   ---- Never or nearly never

9. Do you have high blood pressure?
   ---- Yes
   ---- No
   ---- Don't Know

FINAL RESULT ----High Risk ----Low Risk

STOP BANG Questionnaire:

Do you snore loudly? -----Yes ----No
Do you often feel tired, fatigued, or sleepy during the day? ----Yes -----No
Has anyone observed you stop breathing while you sleep? ---Yes ---No
Are you being treated for high blood pressure? ---Yes ----No
BMI more than 35 kg/m2? (as measured by staff) ----Yes ----No
Are you over age 50 years? ----Yes ----No
Neck circumference greater than 40cm/15.7 inches? (as measured by staff) ----Yes ----No
Gender, male? ----Yes----No

FINAL RESULT ----High Risk ----Low Risk

Social History

Do you currently smoke? ---------How many packs/day? -------- How many years? --------
Did you smoke in the past? ---------- How much? ---------- How long? ----------
Do you drink alcohol? ---------- How much? --------- How often? --------
Do you drink caffeinated beverages? -------- How much? ---------- How often? ----------
Are you: Single ---------- Married ---------- Widowed ---------- Divorced ----------
Are you: Employed --------- Unemployed ---------- Retired ---------- Student----------
Employment type:
------ Day shift
------ Rotating shifts
------ Night shifts
------ Fly to different time zones
------ Drive long distance
------ Student

Do you exercise regularly? ---------- If yes, how often? ----------
Do you have unusual eating habits? ---------- If yes, explain ----------

What is your work schedule? _____

Past Medical History

----------Hypertension
---------- Diabetes
---------- Peripheral Vascular Disease
---------- Anemia
---------- Anxiety / Depression
---------- Psychosis / Schizophrenia
---------- Emphysema
---------- Cancer
---------- Prostrate Problems
---------- Liver Problems
---------- Tonsillectomy
---------- Nasal Fracture
---------- Laser Surgery for Snoring
----------Post Traumatic Stress Disorder (PTSD)
---------- Hypothyroidism
---------- Kidney Disease

---------- Heart Disease
---------- Stroke
---------- Acid Reflux Disease
---------- Heart Attack
---------- Bipolar Disorder
---------- Asthma
---------- Congestive Heart Failure
---------- Sinus Problems
---------- Thyroid Disorder
---------- Seizures
---------- Nasal Surgery
---------- Seasonal Allergies
---------- Chronic Pain
----------Traumatic Brain Injury (TBI)
---------- Atrial Fibrillation
---------- Heart failure

List Other Medical Problems: ----------

☐ **No known Drug Allergy**

Allergies: ----------

☐ **No known Surgical History**

Past Surgical History

List All Surgeries:	**Year:**
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---	---
---	---
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☐ **No known Current Medication**

Medications

Name	**Dose**	**Reason**
---	---	---
---	---	---
---	---	---
---	---	---
---	---	---
---	---	---
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Review of System (Circle all that apply)

Constitutional Systems
Fever Chills Night sweats Changes in appetite

HEENT
Double vision Wear glasses Wear contact lenses Visual changes Headache
Nasal discharge Abnormal sneezing Nose bleeds Postnasal drip
Problems with speech Blurry Vision Nasal congestion Hearing Loss
Problems with swallowing Sore Throat

Respiratory
Dry Cough Cough with sputum Shortness of breath at rest/exertion
Congestion Asthma Wheezing

Cardiovascular
Heart murmur Chest pain Palpitations Edema Skipped beats
Shortness of breath when lying flat

Gastrointestinal
Nausea Vomiting Diarrhea Constipation Abdominal pain Acid Reflux Disease

Genitourinary
Painful urination Menstrual problems Blood in urine Excessive nighttime urination
Urinary frequency Urinary leakage with cough

Psychiatric
Anxiety Depression Psychosis Irritability/mood changes

Neurological
Numbness or tingling on hands or feet Loss of strength

Musculoskeletal
Arthritis or joint pains

Endocrine
Heat/cold intolerance Hair changes Dry skin
Changes in neck size or appearance Glandular or hormone problem

Hematogogic/Lymphatic
Anemia Easily bruising/bleeding

Integumentary
Changes in skin color Changes in hair or nails Rashes Varicose Veins Itching

☐ **No known Family History**

Family History

Relation	Medical Problems
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Thank you for taking time to answer all the questions