RED RIVER SLEEP CENTER

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AASM ACCREDITED

Name: _____ **Date:** _____
First Last Middle

Occupation: _____ Weight: _____ Height: _____ Date of Birth: _____

This Sleep History helps your Sleep Specialist gain an in-depth understanding of your Sleep/Medical background and the nature of your current sleep problem(s). **Please complete all the questions as thoroughly as you can**.

1. Use the lines below to describe your main sleep problem(s) and/or sleep complaint(s):

   _____

   _____

   _____

   _____

2. How often do these symptoms occur? ☐ every night ☐ two or more times a week ☐ other _____
3. How long have you been experiencing these symptoms? ☐ 2+ years ☐ 1- 2 years ☐ several months ☐ last few weeks
4. I am currently on: ☐ CPAP ☐other PAP therapy ☐Oxygen ☐ Other_____
5. Do you have difficulty with? ☐ Thinking ☐ Remembering ☐ Reasoning
6. How long does it take for you to fall asleep? _____, How many times do you typically wake up at night? _____
7. Are your sleep habits on weekends different from the rest of the week? ☐ No | ☐ Yes, please describe _____

   _____
8. Do you usually: ☐ have a bed partner | ☐ sleep with someone else in your room | ☐ Provide assistance to someone during the night
9. Do you work split shifts or rotating (variable) shifts? ☐ Yes | ☐ No
10. Do you feel refreshed after a short nap? ☐ Yes | ☐ No
11. How do you feel after an average night of sleep?

    ☐ Drowsy, sleepy, and/or tired…….. For how long: ☐ 1 hour | ☐ 2 hours | ☐ 3 hours or longer

    ☐ Rested and/or refreshed…….. For how long: ☐ 1 hour | ☐ 2 hours | ☐ 3 hours or longer
12. When do you feel at your best? ☐ Morning | ☐ Afternoon | ☐ Evening
13. What time do you usually go to bed? _____; What time do you usually get out of bed? _____
14. In response to intense emotion (laughter, anger, surprise) have you felt muscle weakness in your legs, neck, arms, eyes, etc? ☐ Yes | ☐ No
    If yes, please describe emotions involved and what muscles were weakened or went limp.

    _____
15. Before you are fully asleep do you have very vivid, sometimes frightening, hallucination like dreams? ☐ Yes | ☐ No
16. Have you ever awakened and felt like your body was "paralyzed", or couldn't move at all, even though you could breathe and see? ☐ Yes | ☐ No

PLEASE CHECK ALL THAT APPLY TO YOUR USUAL ROUTINE:

☐ Exercise regularly
☐ Keep a regular bedtime routine
☐ Give yourself time to relax before bedtime
☐ Take naps longer than 45 minutes daily
☐ Spend enough time in bed to allow for a full sleep period
☐ Feel comfortable in your sleep environment (bed room)
☐ Other bedtime habit(s): _____

☐ Eat large or spicy meals within 2-3 hours of bedtime
☐ Consume caffeine or other stimulants within 5 hours of bedtime
☐ Consume alcohol within 2-3 hours of bedtime
☐ Exercise close to bedtime
☐ Fall asleep with the TV or Radio on
☐ Go to bed when you are NOT sleepy
☐ Take hot bath/shower before bed

WEIGHT CHANGES: Within last three years: GAINED_____ (pounds); LOST_____ (pounds)

SUBSTANCE INTAKE: Do you or someone in your household smoke? (cigarettes/cigars/pipe, etc.) ☐ Yes | ☐ No

Do you use tobacco? ☐ Yes | ☐ No, if yes what type(s) and how often? _____

Do you use alcohol? ☐ Yes | ☐ No, if yes how much and how often? _____

Do you use caffeine? ☐ Yes | ☐ No, if yes how much and how often? _____

ALLERGIES: Are you allergic to Latex, tape or adhesive? ☐ Yes | ☐ No; Do you have any other allergies, drug or otherwise? (Please list all known allergies in the space provided)_____

PAIN: Describe any pain you experience and how often: _____

FALLs: Have you fell in the last 5 years? ☐ Yes | ☐ No; Have you sustained any injuries from falls ? ☐ Yes | ☐ No

SLEEPING POSITION:

☐ All positions
☐ ONLY on my sides
☐ MOSTLY on my stomach
☐ Elevated (wedge, bed, chair)
☐ Only on my stomach
☐ If prescribed by my doctor, YES I could strictly sleep on my left and right sides only
☐ On two or more pillows
☐ MOSTLY on my back
☐ ONLY on my back
☐ MOSTLY on my sides

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. If you haven't done some of these activities recently, please try to estimate how you would typically respond. A score of 11 or more is often sufficient for insurance companies to approve warranted services. Use the following scale to choose the most appropriate number for each situation:

0 = would never sleep | **1** = slight chance of sleeping | **2** = moderate chance of sleeping | **3** = high chance of sleeping

Situation	Chance of Dozing/Sleeping			
Watching TV	**0**	**1**	**2**	**3**
Sitting and reading	**0**	**1**	**2**	**3**
Sitting and talking with someone	**0**	**1**	**2**	**3**
Sitting quietly after a lunch without alcohol	**0**	**1**	**2**	**3**
As a passenger in a car for an hour without a break	**0**	**1**	**2**	**3**
In a car, while stopped for a few minutes in the traffic	**0**	**1**	**2**	**3**
Sitting inactive in a public place (ex: a theater or a meeting)	**0**	**1**	**2**	**3**
Lying down to rest in the afternoon when circumstances permit	**0**	**1**	**2**	**3**

SCORE _____

CURRENT PRESCRIPTION and NON-PRESCRIPTION MEDICATION(S) [If you have a prepared list, please attach it here]

NAME	AMOUNT	HOW OFTEN	REASON

Please check all that apply and list as appropriate:
(Indicate the starting year just above the diagnosis/symptom)

Mental Health:	☐ depression	☐ suicide	☐ alcoholism	☐ mood disorder	☐ anxiety/panic
Nervous System:	☐ diabetes	☐ strokes	☐ seizures	☐ nerve damage	☐ tremors
Pain:	☐ arthritis	☐ fibromyalgia	☐ osteoporosis	☐ back pain	☐ leg pain
Hormones:	☐ high thyroid	☐ low thyroid	☐ menopause	☐ hot flashes	☐ hormone therapy
Disease:	☐ Hepatitis A/B/C	☐ HIV/Aids	☐ Tuberculosis	☐ other _____	

Surgeries: _____

_____

Other not listed above: _____

_____

BED PARTNER QUESTIONNAIRE (To be completed by bed partner, sleep observer, check all that apply)

Name of person completing this form _____ Relationship to patient _____

☐ Snoring ☐ sleep walking/sleep talking ☐ twitching/kicking legs ☐ head banging/rocking ☐ stopped breathing, choking, gasping
☐ acting out dreams ☐ talking during sleep/crying out ☐ apparently sleeping although behaves otherwise

Please describe any other sleep behavior(s), Include: 1) description of behavior, 2) time it occurs, 3) how often, 4) whether it occurs every night

_____

_____

_____