Name: _____

DOB: _____

Conemaugh
Memorial Medical Center

Please complete and return with home sleep study unit.

SLEEP DISORDERS CENTER

General Sleep Assessment

Complete the following questionnaire by filling in the blanks and/or placing a check mark in the appropriate area.

What time do you usually go to bed? _____ ❑ AM ❑ PM

Do you have difficulty falling asleep initially? ❑ Yes ❑ No

If you have difficulty, how long does it take to fall asleep? _____

Do you plan tomorrow's activities while lying in bed? ❑ Yes ❑ No

Do thoughts racing through your mind keep you from sleeping? ❑ Yes ❑ No

Do thoughts keep you up after awakening during the night? ❑ Yes ❑ No

Do you have difficulty staying asleep during the night? ❑ Yes ❑ No

If yes, how many times do you wake up during the night? _____

How long does it take you to fall back to sleep? _____ ❑ Minutes ❑ Hours

When do you typically wake up to start your day? _____ ❑ AM ❑ PM

Do you need an alarm clock? ❑ Yes ❑ No

Do you feel refreshed when you awaken to start your day? ❑ Yes ❑ No

Do you experience unsettled, restless legs while lying in bed? ❑ Yes ❑ No

If yes, how often? ❑ Rarely (25% of the time) ❑ Half (50% of the time) ❑ Most (75% of the time)

Have you been told you kick or twitch while sleeping? ❑ Yes ❑ No

Do you snore at night? ❑ Yes ❑ No

If you snore, how would you rate the severity? ❑ Mild ❑ Moderate ❑ Severe

Do you have pauses in your breathing or gasping while asleep? ❑ Yes ❑ No ❑ Don't Know

If yes, how frequent are the pauses or gasping? ❑ Throughout the night ❑ Frequently ❑ Occasionally

Does your partner sleep in another room due to how you sleep? ❑ Yes ❑ No

Do you frequently wake up with any of these symptoms? ❑ Dry mouth ❑ Headache ❑ Chest pain ❑ Choking or gasping ❑ Nasal congestion ❑ Aching jaws (teeth grinding)

Are you sleepy during the day? ❑ Yes ❑ No

Do you take naps often? ❑ Yes ❑ No

How many caffeinated beverages do you consume each day? _____ (8 oz cups)

Do you occasionally awaken feeling paralyzed? ❑ Yes ❑ No

Have you experienced loss of strength in your arms or legs? ❑ Yes ❑ No

If yes, are they brought on by a sudden fright or laughter? ❑ Yes ❑ No

Name: _____

DOB: _____

Habits

Do you currently smoke? ❑ Yes ❑ No If yes, how many per day? _____ Per week? _____
Do you drink alcohol? ❑ Yes ❑ No If yes, how many drinks per day? _____ Per week? _____
Do you drink caffeine? ❑ Yes ❑ No If yes, how many cups per day? _____ Per week? _____

Medical History:

Height: _____ Weight: _____

*Please check any of the following medical conditions that you **have a history of** OR for which you are **currently undergoing treatment**:*

- ❑ Arthritis
- ❑ Fibromyalgia/Chronic pain
- ❑ Chronic headaches
- ❑ Morning headaches
- ❑ Back problems
- ❑ Muscle Cramps
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Heart problems/heart attack
- ❑ Irregular heart beat
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pacemaker
- ❑ Stroke
- ❑ Asthma
- ❑ COPD
- ❑ Sinus problems/nasal congestion
- ❑ Large tonsils/adenoids/uvula
- ❑ Depression/Anxiety
- ❑ Acid Reflux/heartburn
- ❑ Mental problems
- ❑ Seizures/Epilepsy
- ❑ Kidney/Bladder problems
- ❑ Prostate trouble

Please list any other medical conditions, medical or psychiatric, for which you are undergoing treatment:

_____
_____
_____
_____

Current Medications *(attach separate page, if necessary)*

Medication	Dose	Reason

Allergy to	Reaction

Name: _____

DOB: _____

Previous Sleep Evaluation and Treatment

- ❑ I previously have had a sleep study. When?: _____ Where?: _____
- ❑ I am currently or have used titration therapy for home use. Pressure (if known)_____ cm H20
- ❑ I have had surgical treatment for a sleep disorder. When? _____
- ❑ I am currently or have previously taken prescription sleep medication.
- ❑ I am currently or have previously taken over-the-counter sleep medication.
- ❑ I use oxygen. Number of liters (if known) _____ ❑ All day ❑ Only at night

List any recent surgeries *(including year)*

_____

_____

_____

_____

BED PARTNER SECTION

This final section covers information from your bed partner. Please state their name: _____

How often has your partner observed your sleep? ❑ Every night ❑ Often ❑ Once or twice ❑ Never

Check any of the following behaviors that your partner has observed while you sleep: ❑ Light snoring ❑ Sleepwalking

❑ Loud snoring ❑ Teeth grinding ❑ Sitting up in bed not awake ❑ Choking ❑ Twitching/kicking of arms and legs

Please describe the sleep behaviors checked in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night and whether it occurs every night.

_____

_____

_____

_____

_____

According to your bed partner, have you ever fallen asleep during normal daytime activities or in dangerous situations?

❑ Yes ❑ No

If yes, please explain:

_____

_____

_____

_____

_____