Northeast Georgia
Sleep Medicine
1276 Jesse Jewell Parkway, Suite C
Gainesville Ga, 30501
Phone 678-450-3625 To schedule 770-516-5

# Patient Medical History Page Four

Patient Name: ______________________ DOB: ____/____/____

**Sleep Assessment (continued)**

| *During the night, how often do you:* | Not at all/ None | Slight/ Few times | Moderate/ Sometimes | Often | Severe/ Always |
|---|---|---|---|---|---|
| 38. Sleep with someone else in your room | ☐ | ☐ | ☐ | ☐ | ☐ |
| 39. Sleep with someone else in your bed | ☐ | ☐ | ☐ | ☐ | ☐ |
| 40. Sleep on a special surface | ☐ | ☐ | ☐ | ☐ | ☐ |
| 41. Have restless, disturbed sleep | ☐ | ☐ | ☐ | ☐ | ☐ |
| 42. Disturb the sleep of your bed partner | ☐ | ☐ | ☐ | ☐ | ☐ |
| 43. Provide assistance to someone or something else during the night | ☐ | ☐ | ☐ | ☐ | ☐ |
| 44. Have nasal congestion | ☐ | ☐ | ☐ | ☐ | ☐ |
| 45. Use nasal spray or other medication to deal with nasal congestion | ☐ | ☐ | ☐ | ☐ | ☐ |
| 46. Snore | ☐ | ☐ | ☐ | ☐ | ☐ |
| 47. Hold your breath or stop breathing | ☐ | ☐ | ☐ | ☐ | ☐ |
| 48. Wake up gasping for air or feeling you can't breathe | ☐ | ☐ | ☐ | ☐ | ☐ |
| 49. Wake with a choking sensation | ☐ | ☐ | ☐ | ☐ | ☐ |
| 50. Have some other breathing problem during sleep | ☐ | ☐ | ☐ | ☐ | ☐ |
| 51. Sweat excessively | ☐ | ☐ | ☐ | ☐ | ☐ |
| 52. Sleep walk | ☐ | ☐ | ☐ | ☐ | ☐ |
| 53. Sleep talk | ☐ | ☐ | ☐ | ☐ | ☐ |
| 54. Grind your teeth | ☐ | ☐ | ☐ | ☐ | ☐ |
| 55. Have leg twitching or jerking during your sleep | ☐ | ☐ | ☐ | ☐ | ☐ |
| 56. Have other unusual movements during sleep | ☐ | ☐ | ☐ | ☐ | ☐ |
| 57. Eat during the night after you go to sleep | ☐ | ☐ | ☐ | ☐ | ☐ |
| *During the night, how often is your sleep disturbed because of:* | | | | | |
| 58. Stomach or abdominal pains | ☐ | ☐ | ☐ | ☐ | ☐ |
| 59. Leg cramps | ☐ | ☐ | ☐ | ☐ | ☐ |
| 60. Parasthesia (pins and needles sensation) in your arms or legs | ☐ | ☐ | ☐ | ☐ | ☐ |
| 61. Itching sensations | ☐ | ☐ | ☐ | ☐ | ☐ |
| 62. Feeling short of breath in a flat position | ☐ | ☐ | ☐ | ☐ | ☐ |
| 63. 'gas' in your stomach, or indigestion | ☐ | ☐ | ☐ | ☐ | ☐ |
| 64. Awakening with regurgitation, or burning in your throat | ☐ | ☐ | ☐ | ☐ | ☐ |
| 65. Hunger | ☐ | ☐ | ☐ | ☐ | ☐ |
| 66. Thirst | ☐ | ☐ | ☐ | ☐ | ☐ |
| 67. Awakening with the urgent need to urinate | ☐ | ☐ | ☐ | ☐ | ☐ |
| 68. Intense heart pain (angina) | ☐ | ☐ | ☐ | ☐ | ☐ |
| 69. Other chest pains | ☐ | ☐ | ☐ | ☐ | ☐ |
| 70. Asthma | ☐ | ☐ | ☐ | ☐ | ☐ |
| 71. Persistent coughing | ☐ | ☐ | ☐ | ☐ | ☐ |

72. How long does it take you to "get going" in the morning? ____________ minutes

| | | | | | |
|---|---|---|---|---|---|
| 73. How often do you feel extremely alert and energetic all day? | ☐ | ☐ | ☐ | ☐ | ☐ |

***Thank you! Please bring this form with you to your appointment!***

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# Patient Medical History 

Patient Name: ______________________ DOB: ____/____/____

| *How much of a problem do you have:* *(check box of best answer)* | Not at all/ None | Slight/ Few times | Moderate/ Sometimes | Often | Severe/ Always |
|---|---|---|---|---|---|
| 11. with going to sleep at night | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. because of waking up during the night | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13. not feeling rested, no matter how much sleep you get | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14. with tiredness, not sleepiness, during the day | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15. with sleepiness during the day | ☐ | ☐ | ☐ | ☐ | ☐ |

16. On a **weekday**, what time do you usually ...
    Go to bed: ________am/pm get up: ________am/pm
    Do you normally take naps: ☐ Yes ☐ No
    If yes, how many per day? __________ What time(s)? __________
    How long does your typical nap last? __________minutes / hours
17. On a **week-end or day off**, what time do you usually ...
    Go to bed: ________am/pm get up: ________am/pm
    Do you normally take naps: ☐ Yes ☐ No
    If yes, how many per day? __________ What time(s)? __________
    How long does your typical nap last? __________minutes / hours
18. Do you watch TV or read in bed before going to sleep? ☐ Yes ☐ No
    If yes, how long? ________
19. Do you use sleeping aids or medicine? ☐ Yes ☐ No
    If yes, please list: ______________ how often do you use it? ______________
20. How long are you in bed before deciding to go to sleep? ______ hours ______ minutes
21. How long does it take you to fall asleep after you have decided to? ______ hours ______ minutes
22. How many hours of sleep do you get in a typical night? ______ hours
23. How many times do you wake up in a typical night? ______ times
24. How long is a typical wake time? ______ hours ______ minutes
25. If you do awaken during your sleep, which part(s) of the night is it likely to happen?
    ______ First third ______ Second third ______ Last third
26. How many times do you get out of bed in a typical night? ______ times
27. How long is the typical time out of bed during the night? ______ hours ______ minutes

| *When falling asleep, how often do you:* *(check box of best answer)* | Not at all/ None | Slight/ Few times | Moderate/ Sometimes | Often | Severe Always |
|---|---|---|---|---|---|
| 28. Have thoughts racing through your mind | ☐ | ☐ | ☐ | ☐ | ☐ |
| 29. Feel sad or depressed | ☐ | ☐ | ☐ | ☐ | ☐ |
| 30. Have anxiety, or worry about things | ☐ | ☐ | ☐ | ☐ | ☐ |
| 31. Feel muscular tension | ☐ | ☐ | ☐ | ☐ | ☐ |
| 32. Feel afraid of not being able to go to sleep | ☐ | ☐ | ☐ | ☐ | ☐ |
| 33. Feel unable to move or paralyzed | ☐ | ☐ | ☐ | ☐ | ☐ |
| 34. Notice parts of your body startle or jerk | ☐ | ☐ | ☐ | ☐ | ☐ |
| 35. Experience restlessness in your legs (crawling or aching, unable to keep your legs still) | ☐ | ☐ | ☐ | ☐ | ☐ |
| 36. Experience vivid, dreamlike scenes or hallucinations even though you are awake | ☐ | ☐ | ☐ | ☐ | ☐ |
| 37. Experience pain or discomfort | ☐ | ☐ | ☐ | ☐ | ☐ |

Continued...

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## Patient Medical History Page Two

Patient Name: ______________________ DOB: ____/____/____

Do you have:

| | | |
|---|---|---|
| Frequent or severe headaches | ☐ Yes | ☐ No |
| Difficulty breathing through nose | ☐ Yes | ☐ No |
| Painful sinuses | ☐ Yes | ☐ No |
| Allergies/Hayfever | ☐ Yes | ☐ No |
| Dentures | ☐ Yes | ☐ No |
| Smothering spells at night | ☐ Yes | ☐ No |
| Irregular heart beat | ☐ Yes | ☐ No |
| Chest pain with exercise | ☐ Yes | ☐ No |
| Difficulty swallowing | ☐ Yes | ☐ No |
| Voice changes/ hoarseness | ☐ Yes | ☐ No |
| Frequent cough | ☐ Yes | ☐ No |
| Chronic nasal discharge | ☐ Yes | ☐ No |
| Shortness of breath | ☐ Yes | ☐ No |
| Asthma or wheezing | ☐ Yes | ☐ No |
| Emphysema | ☐ Yes | ☐ No |
| Swollen legs | ☐ Yes | ☐ No |
| Heart enlargement | ☐ Yes | ☐ No |
| Do you sleep on more than one pillow? | ☐ Yes | ☐ No |
| Heartburn | ☐ Yes | ☐ No |
| Hiatal hernia | ☐ Yes | ☐ No |

Comments: (Please explain all 'yes' answers)

______________________________

______________________________

| | | |
|---|---|---|
| Chronic muscular pain | ☐ Yes | ☐ No |
| Localized muscle weakness | ☐ Yes | ☐ No |
| Goiter or thyroid enlargement | ☐ Yes | ☐ No |
| Weight loss | ☐ Yes | ☐ No |
| Weight gain | ☐ Yes | ☐ No |
| Low blood pressure | ☐ Yes | ☐ No |
| Anemia (low hemoglobin) | ☐ Yes | ☐ No |
| Pain in joints | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No |
| High blood sugar | ☐ Yes | ☐ No |
| Abnormal glucose tolerance test | ☐ Yes | ☐ No |
| Low blood sugar | ☐ Yes | ☐ No |
| HIV or AIDS | ☐ Yes | ☐ No |

Comments: (Please explain all 'yes' answers)

______________________________

______________________________

| | | |
|---|---|---|
| History of Stroke | ☐ Yes | ☐ No |
| Memory loss | ☐ Yes | ☐ No |
| Difficulty moving or controlling part of your body | ☐ Yes | ☐ No |
| Tremors or shakes in your arms or legs | ☐ Yes | ☐ No |
| Personality changes | ☐ Yes | ☐ No |
| Diagnosed Depression | ☐ Yes | ☐ No |
| Difficulty sleeping | ☐ Yes | ☐ No |
| "Drop" or paralysis attacks | ☐ Yes | ☐ No |
| Difficulty speaking | ☐ Yes | ☐ No |

Comments: (Please explain all 'yes' answers)

______________________________

______________________________

### Sleep Assessment

The following questions will help us to obtain an understanding of your sleeping problems. It is extremely important that you answer these questions as completely as possible. There are some questions that your bedpartner or room-mate can be helpful with, such as snoring questions.

Do not spend too much time on these questions: your first impression is the best answer in most cases. Answer all questions by considering the past six months, unless otherwise specified. If you are engaged in shift work or other unusual sleep/wake schedule, refer to 'Daytime' as the times you would normally be awake, and 'Nighttime' when you would be sleeping.

1. How many miles do you drive to work each day? ________ Approximately how many miles per year do you drive? ________
2. On a scale of 1 to 10, with 10 being the worst or most problem, how much does sleepiness affect your: (circle one number)
   driving performance? 1 2 3 4 5 6 7 8 9 10 work performance? 1 2 3 4 5 6 7 8 9 10
3. Have you had driving accidents or 'near miss' incidents while driving related to sleepiness? ☐ Yes ☐ No
4. If the answer to number 3 is yes, How many accidents have you had due to sleepiness? ________
   How many near miss incidents have you had due to sleepiness? ________
5. What shift do you normally work? ______ Day /1st ______ Evening / 2nd ______ Night / 3rd ______ Swing
6. How many work related mistakes per year do you have associated with sleepiness? ______ Fatigue? ______
7. How many work related accidental injuries per year do you have associated with sleepiness? ______ Fatigue? ______
8. Do you normally work more than 40 hours per week? ☐ Yes ☐ No

*Do you feel that you:*

9. get too little sleep at night ☐ Yes ☐ No
10. get too much sleep at night ☐ Yes ☐ No

Continued...

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# Patient Medical History Page One

Date: ____/____/____ Patient Name: ____________________

DOB: ____/____/____ Age: ________ Height: ______ inches Weight: ______ lbs Race: ________

Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Occupation: ____________

Primary Care Physician: ____________ Referring Physician: ____________

Sleep Complaint: ____________________

## Past Medical History

Please answer all questions to the best of your ability.

Do you now or have you ever had :

| Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|
| Tuberculosis (TB) | ☐ Yes | ☐ No | Lung Disease | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | Thyroid Disease | ☐ Yes | ☐ No |
| High Blood Pressure | ☐ Yes | ☐ No | Stomach Disease | ☐ Yes | ☐ No |
| Diabetes (Blood sugar high or low) | ☐ Yes | ☐ No | Intestinal Disease | ☐ Yes | ☐ No |
| Heart Attack | ☐ Yes | ☐ No | Peptic Ulcer | ☐ Yes | ☐ No |
| Other Heart Disease | ☐ Yes | ☐ No | Liver Disease | ☐ Yes | ☐ No |
| Kidney Disease | ☐ Yes | ☐ No | Seizures | ☐ Yes | ☐ No |

**Please explain all "Yes" answers:**

____________________

____________________

## Habits

Do you now or have you ever used:

1. Tobacco ( smoke cigarettes, chew tobacco, etc.) ☐ Yes ☐ No If yes, indicate amount per day: ________
   If yes, how long ? ______ years Have you quit? ☐ Yes ☐ No If yes, when? ________
2. Alcohol (beer, liquor, wine, etc.) ☐ Yes ☐ No If yes, indicate amount per day: ________
   If yes, how long? ______ years Have you quit? ☐ Yes ☐ No If yes, when? ________
3. Caffeinated beverages (soda, coffee, tea, etc.) ☐ Yes ☐ No If yes, indicate amount per day: ________
   Have you quit? ☐ Yes ☐ No

## Medications

Please list all medications you are currently taking. Please bring your packages/bottles with you to your appointment.

____________________

____________________

____________________

### Allergies

Please list medication allergies: ____________________

## Operations

Please list any operations you have had:

| | Date | Hospital | Doctor |
|---|---|---|---|
| Tonsillectomy | ______ | ______ | ______ |
| Gallbladder | ______ | ______ | ______ |
| UPPP | ______ | ______ | ______ |
| Other | ______ | ______ | ______ |

Are you in good health now? ☐ Yes ☐ No If no, please describe your current health conditions/illnesses: ________

____________________

____________________

____________________

Continued...