The Heart & Lung INSTITUTE OF UTAH

Name:_____Height:_____ Weight:_____
Name of your Doctor/Doctors you would like our report sent to _____
Please state in your own words the reason you and/or your doctor referred you to our Sleep Disorders Center:

_____

How long have you had your sleep problem?_____

Details:_____
Has your weight changed recently? □Yes □No How much?_____ Over what Time?_____

Sleep Symptoms

Please rate how often you:

		Never	Rarely	Sometimes	Frequently	Constantly
1.	Awake feeling rested and refreshed…….....	□	□	□	□	□
2.	Snore loudly…….....	□	□	□	□	□
3.	Fall asleep while driving……..	□	□	□	□	□
4.	Are told you stopped breathing during sleep...	□	□	□	□	□
5.	Have awakened from snorting in your sleep…	□	□	□	□	□
6.	Awaken short of breath or feeling choked…..	□	□	□	□	□
7.	Have dry mouth in the morning……...	□	□	□	□	□
8.	Have morning headaches……	□	□	□	□	□
9.	Have heartburn or reflux……..	□	□	□	□	□
10.	Experience vivid dream-like scenes upon awakening or falling sleep……	□	□	□	□	□
11.	Have an uncontrollable urge to sleep during the day……..	□	□	□	□	□
12.	Feel knees buckle and arms get weak <u>then fall down to ground</u> when emotional: (laugh/cry)..	□	□	□	□	□
13.	Feel unable to move (paralyzed) when waking from or falling asleep…….…...	□	□	□	□	□
14.	Experience leg cramps, crawling or aching feelings in arms or legs at bedtime……...	□	□	□	□	□
15.	Have to move your legs or arms to get relief from cramps, crawling or aching feelings……	□	□	□	□	□
16.	Are unable to fall asleep	□	□	□	□	□
17.	Wake up during the night and cannot get back to sleep…….....	□	□	□	□	□
18.	Watch the clock while trying to fall asleep…..	□	□	□	□	□
19.	Have racing or busy thoughts while trying to fall asleep……..	□	□	□	□	□
20.	Sleep better when away from home…….	□	□	□	□	□

Sleep Symptoms Part 2:

Do you:

		Yes	No
1.	Have nightmares?	□	□
2.	Act out your dreams?	□	□
3.	Sleepwalk?	□	□
4.	Talk in your sleep?	□	□
5.	Grind your teeth?	□	□
6.	Eat during your sleep?	□	□

Sleep Hygiene and Sleep Schedule

On average,
What time do you go to bed on weekdays?_____ Weekends_____

How long does it take you to fall asleep on weekdays?_____Weekends_____

What time do you wake up on weekdays?_____Weekends_____

Do you take anything to sleep? □Yes □No If yes, what? _____

		Yes	No
1.	Do you sleep with the television on?	□	□
2.	Do you sleep with the radio on?	□	□
3.	Do you sleep with the lights on?	□	□
4.	Do you read in bed?	□	□

Do you change or swing shifts at work? □Yes □No If yes, what hours:_____
Do you work the night shift? □Yes □No If yes, what hours: _____

Health Habits

Do you drink coffee or tea? □Yes □No If yes, how much? _____Cups per day
Do you drink caffeinated soft drinks? □Yes □No If yes, how much? _____Cans/Bottles/cups per day
Do you drink alcohol? □Yes □No If yes, how many servings a day?)_____
(One serving = can of beer, glass of wine, shot of hard liquor) □1 or less □1 to 3 □3 to 6 □more than 6
Do you take any recreational drugs? □Yes □No
Do you currently smoke? □Yes □No
Currently chew tobacco? □Yes □No How many years?
Have you ever been a smoker? (Cigarettes, cigars, pipe) □Yes □No If yes, how many years?_____
If used to smoke: How many packs a day at most:_____When did you quit?_____
Which most accurately reflects your current level of use?
□ N/A Do not currently smoke
If smoking now: □ Mild (3 or less cigarettes, 1 can/pouch or under one pipe bag per week)
□ Moderate (1 pack of cigarettes a day, 1 can/pouch or one pipe bag per day)
□ Heavy (2 packs of cigarettes a day, 2 cans/pouches, 2 pipe bags per day)

Do you have a history of seizures? □Yes □No
Do you have a history of lung disease (i.e., asthma, COPD)? □Yes □No
Do you have a history of acid reflux/GERD/heartburn? □Yes □No

Sleep Symptoms Part 3:

Please list* any major illnesses, chronic conditions or diseases, surgeries or hospitalizations you have had (& if known, the year):_____

_____

_____

_____

Please list any medications* you are taking, and the dosage (if known):_____

_____

_____

_____

_____

_____

Have you had any injuries, including head injuries or loss of consciousness? (if known, please list the year):

_____

_____

Have you had a sleep study before? □Yes □No If yes, where and when?_____

Are you currently using CPAP/BiPAP (or supposed to)? □Yes □ No If yes, what is the setting?_____

Which company provided the CPAP machine to you?_____

Are you on oxygen? □Yes □No If yes, how much?_____

Which company provides your oxygen?_____

Is there any additional information you think might be important for us to know?

_____

_____

_____

*You may also bring a printed list with you.

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How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your normal every day life. 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 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____