GRANGER MEDICAL CLINIC | *Pulmonary & Sleep Medicine*

ACCT #: _____

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Patient History Sleep Form

Date: _____

Name:	DOB:
Phone:	Gender: ☐ Male ☐ Female

Occupation:	Chief Reason for Sleep Evaluation:
Referring Physician:	Primary Physician:

Have you ever seen a Sleep Specialist before? ☐ Yes ☐ No

Have you been told you have Sleep Apnea? ☐ Yes ☐ No

Do you have any of the following Symptoms? Please check all that apply:

____Morning Headaches ____Snoring ____Moodiness

____Memory Impairment ____Difficulty concentrating ____Excessive Daytime Sleepiness

____Lack of Energy ____Large Neck Size ____Depression

____Obesity

Nighttime: Gasping _____ Choking _____ Coughing _____ Other:_____

What is your usual bedtime?_____Weekend?_____

What is your usual wake time?_____Weekend? _____

How many hours of sleep do you usually get?_____ Weekend? _____

Are you a shift worker? ☐Yes ☐No if yes, how often do you change shift? _____

Current Shift hours: From _____ To _____since (date):_____

***If you see a Granger doctor we have access to your medications there is no need to write them down. (Please attach a list if needed).**

Medication:	Dose:	Frequency:

Medication Allergies (please list any allergies to any drugs and reactions, i.e, "Penicillin – Causes rash"):

Medication:	Reaction:	Medication:	Reaction:

Social History:

Tobacco: Yes___ No___ Cigarettes: ___ packs per day Currently Smoking: Yes___ No___

Age Started:___ Age Quit:___ Cigars:___ Pipe:___ Chew:___

Caffeine: Yes___ No___ Coffee: ___ cups per day Soda: ___ ounces per day Other:___ ounces per day

Alcohol: Yes___ No___ Beer: ___ cans/glasses per week Wine: ___ glasses per week

Hard Liquor: ___ ounces per week

Substance Abuse: Yes___ No___ If yes, please describe:_____

_____

Past Medical History: Please check all that apply

☐ No Medical Problems	☐ High Cholesterol	☐ High Blood Pressure	☐ Pacemaker
☐ Diabetes	☐ High Thyroid	☐ Low Thyroid Depression	☐ Paralysis
☐ Anxiety	☐ Osteoarthritis	☐ Rheumatoid Arthritis	☐ Seizure
☐ Stroke	☐ Atrial Fibrillation	☐ Seasonal Allergies	☐ Headaches
☐ Tremor Passing Out / Fainting	☐ Congestive Heart	☐ COPD Asthma	☐ Loss of Sensation

☐Other:_____

Past Surgeries: Please list what year(s):

____No past surgeries

□ Tonsillectomy _____ □ Mastectomy _____ □ Gallbladder removal _____

□ Hysterectomy_____ □ Vasectomy_____ □ C-Section _____

□ Cancer:_____ □ Other: _____

Previous Sleep Testing:

Have you had a previous sleep test? □ Yes □ No If yes, where:_____

(If your answer is no please continue to question 1-24)

Are you currently on:

□ Oxygen: How Much _____ How Long _____

□ CPAP: What Pressure _____ How Long _____

□ BiPAP: What Pressure _____ How Long _____

How do you feel since using CPAP?: □ Worse □About the same □Better □Much Better

Yes and No Questions:

1. ☐Yes ☐No Do you experience daytime sleepiness?
2. ☐Yes ☐No Do you take daytime naps?
3. ☐Yes ☐No Have you ever fallen asleep while driving or at a stop sign?
4. ☐Yes ☐No Have you been told that you snore?
5. ☐Yes ☐No Have you been told you hold your breath when you sleep?
6. ☐Yes ☐No Have you ever snored or gasped yourself awake?
7. ☐Yes ☐No Do you experience morning headaches?
8. ☐Yes ☐No Do you experience hoarseness or throat irritation?
9. ☐Yes ☐No Do you experience itchy or crawly sensations in your legs at bedtime?
10. ☐Yes ☐No Have you been told that you kick at night?
11. ☐Yes ☐No When angry or happy, have you ever lost muscle strength?
12. ☐Yes ☐No Have you been unable to move upon awakening?
13. ☐Yes ☐No Have you experienced hallucinations upon sleeping or waking?
14. ☐Yes ☐No Do you have difficulty initiating sleep?
15. ☐Yes ☐No Do you feel depressed?
16. ☐Yes ☐No Do you have racing thoughts?
17. ☐Yes ☐No Do you awaken earlier than you would like to in the morning?
18. ☐Yes ☐No Do your thoughts prevent you from falling asleep at night?
19. ☐Yes ☐No Do you drink caffeine in the evenings?
20. ☐Yes ☐No Do you use tobacco in the evenings?
21. ☐Yes ☐No Do you use illicit drugs?
22. ☐Yes ☐No Do you use alcohol in the evenings?
23. ☐Yes ☐No Do you use medication to help you sleep?
24. ☐Yes ☐No Do you use medication to help you stay awake?

STOP-BANG Questionnaire:

Please answer the eight questions below to help us assess for possible Sleep Apnea, a condition in which your breathing pauses or stops for periods of time while you sleep. Sleep Apnea can increase your risk for many health conditions. It can also increase your risk of breathing problems after surgery. If you are at risk of Sleep Apnea, your surgeon may ask you to be evaluated by a sleep physician prior to any surgery. This is for your own safety.

**Note: If you have Sleep Apnea and are having surgery, it is important you let your surgeon and anesthesiologist know you have this diagnosis. You will also need to bring your CPAP machine to the procedure for use before and after surgery while sleeping.*

1. ☐ Yes ☐ No Snoring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors?
2. ☐ Yes ☐ No Tiredness/Fatigue: Do you often feel tired, fatigued, or sleepy during the daytime, even after a good night's sleep?
3. ☐ Yes ☐ No Observed Apnea: Has anyone ever observed you stop breathing during the night?
4. ☐ Yes ☐ No Pressure: Do you have or are you being treated for high blood pressure?
5. ☐ Yes ☐ No Age: Are you older than 50 years?
6. ☐ Yes ☐ No Neck Size: Does your neck measure more than 16 inches (40cm) around?
7. ☐ Yes ☐ No Gender: Are you male?
8. ☐ Yes ☐ No Body Mass Index: Do you weigh more for your height than is shown in the table below?

Height	Weight (lb)	Height	Weight (lb)
4'10"	167	5'8"	230
4'11"	173	5'9"	237
5'	179	5'10"	243
5'1"	185	5'11"	250
5'2"	191	6'	258
5'3"	197	6'1"	265
5'4"	204	6'2"	272
5'5"	210	6'3"	279
5'6"	216	6'4"	287
5'7"	223	6'5"	295

Weights shown in the table above correspond to a BMI of 35 for a given height

EPWORTH SLEEPINESS SCALE

KEY

0 = Would ***NEVER*** Doze
1 = ***SLIGHT*** Chance of Dozing
2 = ***MODERATE*** Chance of Dozing
3 = ***HIGH*** Chance of Dozing

Situation	Do you ever doze off when? (Use key above)			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (ex: theater, meeting)	0	1	2	3
As a passenger in a car, for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3