Comprehensive Sleep and Breathing Disorders Center, P.C.

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SLEEP HISTORY AND PHYSICAL

Consulting MD:

NAME: **SEX: M F AGE:** **Primary MD:** **Date:**

(For the following, Circle as applicable, may take the help of companion)

CHIEF COMPLAINT: **D**aytime sleepiness, **I**nsomnia, **S**noring, **B**reathing difficulty, **L**eg jerks
How long has it bothered you? Less than 3 months, 6-12 months, 1-2 years, longer than 2 years
OTHER:

Snoring- Do you snore? ***Yes No*** If yes, Severity – ***Mild Moderate Loud Very loud***
How long?
Worse on- ***side back***
Does it awaken you? ***Yes No***

Apnea-Do you or have you been told that you stop breathing during sleep? ***Yes No*** .
If yes, How frequently?
Do you snore, then pause? ***Yes No***
How long are pauses in sleep?
How long ago did they start?
Does patient look like s/he is trying to breathe but can't get breath in?
Does patient then take a long breath and partly awaken?

Awakening: Shortness of breath or choking upon awakening? ***Yes No***
Any burping up of sour fluid from stomach? ***Yes No***
Do you awaken in sleep? ***Yes No*** if yes, Describe
Do you have trouble trying to sleep? ***Yes No*** if yes,Describe:

ANCILLARY SYMPTOMS:
Memory loss ***Yes No***
Decreased concentration ***Yes No***
Weight gain ***Yes No***
Automatic behavior (walk into room and forget mission) ***Yes No***
Sexual dysfunction ***Yes No***
Morning headaches ***Yes No***
Irritability ***Yes No***
Fatigue ***Yes No***
Excessive sweating ***Yes No***
Dry mouth in the morning ***Yes No***