Comprehensive Sleep and Breathing Disorders Center PMD/REF MD:

Patient Name: **DOB:** **M/F** **Date of Service:**

Patient Consented to (if) Telehealth Visit--Type of Visit: Video or Audio Only

History of Present Illness Reason for Visit:

Family History of OSA: Yes or No **Prior Sleep Study:** Yes or No **Used CPAP:** Yes or No

Snoring : Frequency: Occasional Frequent Nightly Volume: Soft Med Loud How long:

Does it awake patient/others: Yes or No Worsening Factors: Alcohol Position

Associated Symptoms: Does Patient Wake up Gasping or Choking/stop breathing: **Yes or No**

Has any Witnessed: **Yes or No** Nocturnal Heartburn: **Yes or No**

Nocturia Frequency: _____times/night Have dry mouth in the morning: **Yes or No**

Morning Headache: **Yes or No** Weight Gain: **Yes or No** Night Sweats: **Yes or No**

Memory Loss: **Yes or No** Automatic Behavior: **Yes or No** Decreased Concentration: **Yes or No**

Irritability in the morning: **Yes or No** Sexual Dysfunction: **Yes or No**

Does patient have Excessive Daytime Sleepiness (EDS): Yes or No

How long has EDS been occurring? Is patient sleepy during the workday? **Yes or No**

Are there safety concerns? **Yes or No** Motor Vehicle Collisions Due to Sleepiness: **Yes or No**

Does patient use aids to stay awake ex. Caffeine: **Yes or No**

Has patient experienced cataplexy (The sudden loss of muscle tone while awake, which causes weakness and a loss of voluntary muscle control**): Yes or No**

Sleep Paralysis/Hallucination/ Acting out dreams/Nightmares **Yes or No**

Epworth Sleepiness Scale: how likely are you to doze off or feel sleepy in the following situations:

0= would *never* doze **1= *slight*** chance of dozing **2 =*moderate*** chance of dozing 3 =***high*** chance of dozing

Sitting and reading	**0**	**1**	**2**	**3**
Watching television	**0**	**1**	**2**	**3**
As a passenger in a car for over an hour without a break	**0**	**1**	**2**	**3**
Sitting inactive in a public place (ex. theater or meeting)	**0**	**1**	**2**	**3**
Lying down to rest in the afternoon when circumstances permit	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**
Sitting quietly after lunch without alcohol	**0**	**1**	**2**	**3**
In a car, while stopped in traffic for a few minutes	**0**	**1**	**2**	**3**

Insomnia

Does Patient have Insomnia: **Yes or No** __ months /yrs.

Type of Insomnia: Staying asleep or Falling Asleep or Early morning awakening

Is Insomnia Better: In another place, Another room, On Vacation, On the Weekend

Triggers (e.g.: stress, work, family) Anxiety around sleep: **Yes No**

Previous Treatment: Current Insomnia meds/ OTC meds:

Clock/TV watching: **Yes or No** Disruptive Environmental/Bedroom stimuli: **Yes No**

Typical Night Routine

Preferred Timing: Morning Lark Night Owl Usual Bedtime: Weekends:

Does Patient work a shift work type of job? **Yes or No** Shift Schedule:

What does patient do before bed? Read, Watch TV, Phone or use the Computer

Is Bedtime Regular: **Yes or No** How long does it take for patient to fall asleep?

Estimated total sleep time: How many times does patient wake during the night?

How long are they awake typically and reason?

Does he/she watch the clock or TV? **Yes or No**

What time does patient wake up:

How does patient feel? Sleepy Unrefreshed Tired Groggy

Naps/Other Pertinent Information

Does patient nap: **Yes or No** If patient takes naps, are they refreshing? **Yes or No**

Does patient sleep later on the weekends? **Yes or No**

Leg Jerks/Restless legs Does patient experience RLS? Yes or No Worse in evening **Yes No**

Urge to move? **Yes No** If so, do symptoms improve with activity? **Yes or No**

Frequency Severity Time of onset

Symptom Location Associated H/O Neuropathy, Anemia

Triggers----Pregnancy, Caffeine Tobacco, Alcohol, Meds

Previous Treatment:

Parasomnias: Sleep Talking: Yes or No Sleepwalking: Yes or No safety/Counter measures

Teeth Grinding: Yes or No Nightmares: Yes or No Acting out Dreams/Vivid Dreams: Yes or No

Nocturnal Eating: Yes or No Sleep Paralysis: Yes or No Hallucinations: Yes or No

Triggers—Alcohol/ Sleep deprivation/Meds/ Others