Patient name: _____
Date of birth: _____

BAPTIST HEALTH®
MEDICAL GROUP

SLEEP CENTER STANDARD HISTORY FORM

Home phone: _____ Work phone: _____ Cell phone: _____
Referring physician (first and last name): _____ Self-referral? ❑Yes ❑No
Briefly describe the problem you are having with sleep and the reason you are being referred to the Sleep Center: _____

Check the box if you have ever had the following.

❑Snoring
❑Witnessed apnea
❑Daytime sleepiness/fatigue
❑Frequent awakening
❑Morning headaches
❑Nonrestorative sleep
❑Heartburn/reflux
❑Dry mouth
❑Sore throat
❑Airway abnormalities
❑Facial abnormalities
❑History of broken nose
❑Nasal allergies
❑Grinding teeth
❑Leg/body jerks
❑Leg cramps
❑Frequent nighttime urination 1-2 times per night
❑Frequent nighttime urination 3-4 times per night
❑Difficulty falling asleep
❑Difficulty staying asleep
❑Pain at night
❑Sleep walking
❑Sleep talking
❑Nightmares
❑Nighttime sweating
❑Acting out dreams
❑Seizures
❑Memory loss
❑Lack of concentration
❑Decreased libido
❑Abnormal heart rhythm
❑Heart failure
❑Uncontrollable muscle weakness
❑Hallucinations when falling asleep
❑Hallucinations when waking up
❑Uncontrollable need to sleep
❑Other_____

How long have you experienced symptoms?
❑< 1 year ❑1-2 years ❑2-3 years ❑3-4 years ❑4-5 years ❑>5 years
Do these symptoms affect your work/home life? ❑Yes ❑No If yes, please explain: _____
Have you ever had a sleep consultation? ❑Yes ❑No If yes, where: _____ when:_____
Have you ever had a sleep study? ❑Yes ❑No If yes, where: _____ when:_____
If yes, are you currently on CPAP or BiPAP treatment? ❑Yes ❑No
If yes, what company do you use? Have you ever tried an oral appliance for sleep apnea? ❑Yes ❑No
If yes, what appliance did/do you use?_____

Sleep schedule

Weekday time you go to bed:_____ Weekend time you go to bed:_____
Weekday time you get up:_____ Weekend time you get up:_____
Estimated average amount of sleep per night: _____
How long does it take you to go to sleep at night? _____
Do you feel rested after waking up? ❑Yes ❑No
Do you take naps? ❑Yes ❑No If yes, how long?_____
Do you use medication or alcohol to help you fall asleep?_____

Patient name: _____
Date of birth: _____

BAPTIST HEALTH®
MEDICAL GROUP

Other information

Occupation:_____ Do you have rotating or night shift work? ❑Yes ❑No
If yes, please describe: _____
Does your job require driving a vehicle or do you work with dangerous or potentially dangerous substances or in hazardous or potentially hazardous situations? ❑Yes ❑No
What was your weight?
6 months ago: _____ 2 years ago:_____ At age 20: _____ When heaviest:_____

Social

Do you use tobacco? ❑Yes ❑No
If yes: ❑Cigarettes ❑Pipe ❑Cigars ❑E-cigarettes ❑Snuff ❑Chew
Start date:_____ Quit date:_____
Packs/day: ❑0.25 ❑0.5 ❑1 ❑1.5 ❑2 ❑3
Years ❑0.5 ❑1 ❑2 ❑3 ❑4 ❑5 ❑10 ❑15
Do you use alcohol? ❑Yes ❑No
How often do you have a drink containing alcohol?
❑Never ❑Monthly or less ❑2-4 times a month ❑2-3 times a week ❑4 or more times a week
How many drinks containing alcohol do you have on a typical day when you are drinking?
❑1 or 2 ❑3 or 4 ❑5 or 6 ❑7 -9 ❑10 or more
How many drinks per week? Glasses of wine:_____ Cans of beer:_____ Shots of liquor:_____
Have you ever used marijuana, cocaine, or other recreational drugs? ❑Yes ❑No
If so, which drug(s)?_____ Uses/week:_____
Check all that apply.
Are you a coffee drinker? ❑Yes ❑No ❑Regular ❑Decaf Quantity daily:_____
Are you a tea drinker? ❑Yes ❑No ❑Regular ❑Decaf Quantity daily:_____
Are you a cola drinker? ❑Yes ❑No ❑Regular ❑Decaf Quantity daily:_____

Allergies

Do you have any allergies? ❑Yes ❑No
If yes, please list (environmental, food, medications):_____

Pharmacy

Please indicate the name and location of the pharmacy you most frequently use.

_____

Medications

Have you ever been placed on any medication to help you sleep or stay awake: ❑Yes ❑No
If yes, please list: _____
Are you currently using supplemental oxygen? ❑Yes ❑No If yes, at what rate? ____ LPM
If yes, do you use oxygen during: ❑Daytime ❑Nighttime ❑Continuously throughout the day and night

Patient name: _____
Date of birth: _____

BAPTIST HEALTH®
MEDICAL GROUP

Current medications

Please list all prescriptions and over-the-counter medications, herbal drugs and vitamins (include dose and frequency).

Name of drug/medicine /vitamin	Dosage (if known)	Frequency	Name of drug/medicine /vitamin	Dosage (if known)	Frequency
1.			8.		
2.			9.		
3.			10.		
4.			11.		
5.			12.		
6.			13.		
7.			14.		

Past medical history

Check the box if you have ever had the following.

❑Abnormal heart rhythm
❑Arthritis
❑Congestive heart failure
❑COPD/emphysema
❑Coronary artery disease
❑Diabetes
❑Chronic pain
❑Restless legs syndrome (RLS)
❑High blood pressure
❑Mental disorder
❑Seizures
❑Stroke
❑Thyroid disease
❑Tuberculosis
❑Ulcers
❑Neuromuscular disorder
❑Other _____

Surgical history

Check the box if you have ever had the following.

❑Appendectomy
❑CABG – heart surgery
❑Hernia repair
❑Weight loss surgery
❑Wisdom teeth extraction
❑Nasal polypectomy
❑Sinus surgery
❑Tonsillectomy (tonsils removed)
❑Other _____

Patient name: _____
Date of birth: _____

BAPTIST HEALTH®
MEDICAL GROUP

Family history

Please check all that apply and identify who in your immediate family is affected (father, mother, brother(s), sister(s):

Indicate family member
❑Diabetes mellitus
❑Heart disease
❑Hypertension
❑Stroke
❑Obesity
❑Sleep apnea
❑Narcolepsy
❑Other sleep disorder
❑Hypersomnolence/daytime sleepiness
❑COPD
❑Chronic bronchitis
❑Emphysema
❑Asthma
❑Thyroid disease
❑Cancer
❑Parkinson's disease
❑Restless legs syndrome
❑Insomnia
❑Other_____

Patient name: _____
Date of birth: _____

BAPTIST HEALTH®
MEDICAL GROUP

Review of systems

Check the box if you are experiencing any of the following.

Constitution
- ❑Activity change
- ❑Appetite change
- ❑Chills
- ❑Diaphoresis
- ❑Fatigue
- ❑Fever
- ❑Unexpected weight change

Head, ears, nose, throat
- ❑Congestion
- ❑Dental problem
- ❑Drooling
- ❑Ear discharge
- ❑Ear pain
- ❑Facial swelling
- ❑Hearing loss
- ❑Mouth sores
- ❑Nosebleeds
- ❑Postnasal drip
- ❑Rhinorrhea (runny nose)
- ❑Sinus pain
- ❑Sinus pressure
- ❑Sneezing
- ❑Sore throat
- ❑Tinnitus
- ❑Trouble swallowing
- ❑Voice change

Eyes
- ❑Eye discharge
- ❑Eye itching
- ❑Eye pain
- ❑Eye redness
- ❑Photophobia
- ❑Visual disturbance

Respiratory
- ❑Apnea
- ❑Chest tightness
- ❑Choking
- ❑Cough
- ❑Stridor
- ❑Wheezing

Cardiovascular
- ❑Chest pain
- ❑Leg swelling
- ❑Palpitations

Gastrointestinal
- ❑Abdomen distention
- ❑Abdominal pain
- ❑Anal bleeding
- ❑Blood in stool
- ❑Constipation
- ❑Diarrhea
- ❑Nausea
- ❑Rectal pain
- ❑Vomiting

Endocrine
- ❑Cold intolerance
- ❑Heat intolerance
- ❑Polydipsia
- ❑Polyphagia
- ❑Polyuria

Genitourinary
- ❑Difficulty urinating
- ❑Dysuria
- ❑Enuresis
- ❑Flank pain
- ❑Frequent urination
- ❑Genital sore
- ❑Hematuria
- ❑Penile discharge
- ❑Penile pain
- ❑Penile swelling
- ❑Scrotal swelling
- ❑Testicular pain
- ❑Urgency
- ❑Urine decreased
- ❑Decreased libido

Musculoskeletal
- ❑Arthralgias
- ❑Back pain
- ❑Gait problem
- ❑Joint swelling
- ❑Myalgia (muscle pain)
- ❑Neck pain
- ❑Neck stiffness

Skin
- ❑Color change
- ❑Pallor
- ❑Rash
- ❑Wound

Allergy/immunologic
- ❑Environmental allergy
- ❑Food allergy
- ❑Immunocompromised

Neurological/brain
- ❑Dizziness
- ❑Facial asymmetry
- ❑Headaches
- ❑Light-headedness
- ❑Numbness
- ❑Seizures
- ❑Speech difficulty
- ❑Syncope
- ❑Tremors
- ❑Weakness

Hematologic
- ❑Adenopathy
- ❑Bruises/bleeds easily

Psychiatric
- ❑Agitation
- ❑Behavioral problem
- ❑Confusion
- ❑Decreased concentration
- ❑Dysphoric mood
- ❑Hallucinations
- ❑Hyperactivity
- ❑Nervous/anxious
- ❑Self-injury
- ❑Sleep disturbance
- ❑Suicidal ideas

Patient name: _____
Date of birth: _____

BAPTIST HEALTH®
MEDICAL GROUP

Bed partner questionnaire

Ask someone familiar with your sleep to answer the following questions about you (spouse, parent, etc.).

Name of person filling out this section: _____

Does this patient:

Stop breathing in his/her sleep? ❑Yes ❑No

How often do the pauses in breathing occur? ❑Every night ❑Occasionally ❑Multiple times per night

Snore heavily? ❑Yes ❑No

Snore continuously? ❑Yes ❑No

Snore every night? ❑Yes ❑No

Snore in the following positions? ❑Back ❑Left side ❑Right side ❑All positions

Kick and jerk frequently? ❑Yes ❑No

Sleep walk frequently? ❑Yes ❑No

Talk in his/her sleep? ❑Yes ❑No

Have epileptic seizures during the night? ❑Yes ❑No

Comments:_____

_____

_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, even if you have not done the activity recently? Use the following scale to choose the most appropriate number for each situation.

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

	0	1	2	3
Sitting and reading	❑	❑	❑	❑
Watching TV	❑	❑	❑	❑
Sitting, inactive, in a public place such as 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 lunch without alcohol	❑	❑	❑	❑
In a car, while stopped for a few minutes in traffic	❑	❑	❑	❑

Total score:_____

Thank you for filling out this questionnaire. Your cooperation is greatly appreciated. This information will help us provide the best possible healthcare for you or your loved one.

Patient signature: _____ Date:_____