Elliot Sleep Evaluation Center
At River's Edge
185 Queen City Ave
Manchester, NH 03101 603-663-6680

Center for Sleep Evaluation

SLEEP HISTORY FORM

Name: _____ Today's Date: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip : _____

Home phone: _____ Work phone: _____

Cell Phone: _____

Did you first learn about the Center for Sleep Evaluation from your doctor? _____ Yes _____ No

If no, how did you hear about us? _____

Where did you first hear about sleep disorders? _____

My main sleep complaint involves (mark all types that apply and describe):

_____ trouble sleeping at night _____ being sleepy all day _____unwanted behaviors during sleep (explain below)

Please describe your sleep problem(s): _____

_____

_____

My sleep/wake problem began (date and details): _____

_____

_____

_____

What have you done to treat your problem? _____

_____

_____

_____

I hope the Sleep/ Wake Disorders Center staff will help me by : _____

_____

_____

Sleep Evaluation Questionnaire

1	2	3	4	5	6	7
None or Never	Very Slight or Rarely	Slight or Seldom	Moderate or Occasional	Major or Often	Great or Very Often	Very Great or Always

1 2 3 4 5 6 7 How often do you fall asleep during the day, particularly when you are still or not busy?

1 2 3 4 5 6 7 How great of a problem do you have with non-restorative or restless sleep? (that is no matter how much sleep you get, you don't wake up feeling rested)

1 2 3 4 5 6 7 How often do you drift off while driving?

1 2 3 4 5 6 7 Do you suffer from unexplained fatigue during the day?

1 2 3 4 5 6 7 Do you snore during sleep?

1 2 3 4 5 6 7 How often has a bed partner noted that you hold or stop breathing during sleep?

1 2 3 4 5 6 7 How often is your sleep disturbed by other breathing problems?

1 2 3 4 5 6 7 Do you suffer from headaches upon wakening?

1 2 3 4 5 6 7 How often do you awaken because of heartburn or regurgitation ? (burning in the throat or gagging on stomach contents)

1 2 3 4 5 6 7 How often is your sleep disturbed because of chest pain or angina?

1 2 3 4 5 6 7 How often has a bed partner noted that your legs twitch or kick in your sleep?

1 2 3 4 5 6 7 How often are you troubled by restless or "creepy" leg in the evening or night?

1 2 3 4 5 6 7 How often go you feel unable to move (paralyzed) when just falling asleep or waking up?

1 2 3 4 5 6 7 How often do you have dream like images (hallucinating people or sounds in the room) when just falling asleep or awakening, even though you know that you are not asleep?

1 2 3 4 5 6 7 How often during the day do you have episodes of sudden muscular weakness when laughing, angry, or in other emotional situations?

1 2 3 4 5 6 7 How often is your sleep disturbed by other problems? (Walking, nightmares, abnormal behaviors, etc.)

What time do you usually go to bed? _____ AM / PM

How long does it usually take you to fall asleep after deciding to go to sleep? _____ Hr _____Min.

How many times do you wake up during a typical night? _____ times

What are the total hours of sleep that you usually get at night _____ Hr. _____Min.
(do not include the time you spend awake in bed at night)

MEDICAL HISTORY

Height _____ Weight _____ pounds Last physical exam(year) _____

Do you currently smoke? _____ Yes _____ No

If no, but you smoked in the past, how long has it been since you stopped? _____
For how many years did(have you smoked? _____
How many cigarettes, cigars, pipefuls of tobacco do(did) you use daily (please circle type of usage) _____

List briefly the health problems you have had and their treatment:

SYSTEM	PROBLEM/TREATMENT	DATE	TREATING PHYSICIAN CLINIC OR HOSPITAL
Respitory conditions (asthma,COPD,etc)			
Eyes,ears,nose,throat/mouth (glaucoma,sinus obstruction, alergies, surgery, etc)			
Heart,circulation,blood pressure			
Stomach,digestive,intes.dis			
Kidney,uroligical,or sexual disease			
Head/Nervous system (e.g., Head trauma, convulsions):			
Psychological/Psychiatric:			
Accidents, Injuries, (e.g. Bone fracture, dislocations):			
Surgical operations, (e.g., Tonsillectomy, nasal surgery Hysterectomy, etc.):			
Other conditions (e.g., Painful conditions, Hormone abnor.,diabetes,thyroid,etc):			

Please list ALL medications(prescribed by a doctor or non prescribed(Unisom, sominex, Viovarin,etc) that you have ever taken for your sleep problems:

MEDICATION FOR SLEEP	Dose	Times Daily	How long Used	Use it Now	When Stopped	Prescribing MD

Apart from sleep medicines listed above, name all other medications you are currently taking(prescribed or otherwise):

CURRENT MEDICATION	Dose	Times Daily	How long Used	Use it Now	When Stopped	Prescribing MD

FAMILY HEALTH HISTORY: For each family member, write current age or age at death, present state of health(good, fair, poor) or cause of death, as well as sleep problems(snoring,insomnia,sleepiness, etc) and major illnesses.

RELATIONSHIP	If living, Age/Health	If deceased, Age/Cause	Sleep/ Medical problems
Father			
Mother			
Spouse			
Brothers			
Sisters			
Children			

NUTRITION ASSESSMENT

Special diet? Yes / No
If yes, please describe your diet _____

Do you use any diet products? Yes/ No
If yes, please describe _____

How many meals do you eat each day? _____ How Many snacks? _____

Do you exercise or play sports? Yes/ No
If yes, how many days per week do you exercise? _____
How long do you usually exercise? _____

Please describe your exercise: _____

_____

Do you want help in planning your diet or losing weight? **Yes / No**

In the last 12 months how many pounds have you (please circle appropriate term) gained or lost? _____

In the last 4 months how many pounds have you (circle appropriate term) gained or lost? _____

List the amounts of the following beverages you consume. If not used everyday, list in the far right column the average per week.

	Daily	After 6 p.m.	Weekly
Cups of coffee			
Decaffeinated Coffee (cups)			
Tea (glass or cups)			
Carbonated drinks (cans/bottles)			
Beer, Wine, liquor (cans/ bottles)			
Recreational Drugs (list _____)			

Name and address of regular physician

_____

_____

_____

_____

Name and address of referring physician
(if not your regular physician)

_____

_____

_____

_____

Use the space below for additional comments that you may wish to make about your health, or intake of drugs, medicines, or alcohol.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Elliot Sleep Evaluation Center
At River's Edge
185 Queen City Ave
Manchester, NH 03101 603-663-6680

Name of bed partner _____ Date _____

I have observed this person's sleep:
_____Never _____ Once or twice _____Often _____ Almost every night

Check any of the following behaviors that you have observed this person doing while asleep. Circle those that you consider severe problems for this person.

_____ light snoring
_____ loud snoring
_____ loud snorts
_____ choking
_____ pause in breathing(how long?_____Seconds)
_____ gasping for air
_____ twitching or kicking of the legs
_____ twitching or flinging of arms
_____ sleep talking
_____ grinding teeth
_____ bed wetting
_____ sitting up in bed not awake
_____ awakening with pain
_____ head rocking or banging
_____ getting out of bed not awake
_____ biting tongue
_____ becoming very rigid and/or shaking
_____ crying out
_____ apparently sleeping even if he/ she behaves otherwise
_____ other(explain)_____

If this person snores, what makes it worse?

_____ Sleeping on his/her back _____ Sleeping on his/her side _____ alcohol _____ fatigue

Does the snoring sometimes require you or your partner to sleep separately? _____ Yes _____ No

Describe the sleep behaviors checked in more detail. Describe the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

_____

_____

_____

_____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations?
_____Yes _____ No If yes, please explain: _____

_____

_____

_____

Does this person use sleeping pills? _____ Yes _____ No If yes, how many pills per week?

_____ Less than 1 per week _____ 1-3 per week _____ 4-7 per week _____ 7+ per week

Do you consider this usage a problem? _____ Yes _____ No _____ Uncertain

Comments: _____

_____

Does this person drink alcohol? _____ Yes _____ No

If yes, this person usually drinks: (check as many as you believe appropriate)
_____ Beer _____ Wine _____ Shots of liquor

Please estimate the per week use of:

_____ 12oz bottle/can/tap beer

_____ 6-8 oz glasses or wine

_____ 1-1 1/2oz of liquor

Please estimate how much this person drinks in the 3 hours before bed. _____

Do you consider this person's drinking a problem? Yes No Uncertain

Comments: _____

_____

If this person uses street drugs, please describe both types and frequency of usage: _____

_____

_____

Do you believe that this person and yourself share the same understanding about his/ her sleep problem, sleeping pill usage, and alcohol/drug usage? _____ Yes _____ No

Comments: _____

_____

_____

Thank you.

Signed _____ Realtionship to bed partner: _____

Elliot Sleep Evaluation Center
At River's Edge
185 Queen City Ave
Manchester, NH 03101 603-663-6680

NAME: _____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situation, in contrast to feeling just tired? This refers to your usual way of life in recent times. 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= Would never doze
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 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	_____

Thank you for your cooperation