WESTERN RESERVE HOSPITAL
Proudly Physician Owned

SLEEP STUDIES
PERSONAL HISTORY FORM

Name: _____ Date: _____

Referred by: _____ Family Doctor: _____

Age: _____ Height: _____ Weight: _____ Handedness: ◻ Right ◻ Left

Medical problem I'm seeing a Neurologist/Sleep Specialist for: _____

_____

Past Medical History (check all that apply):

◻ Heart Attack	◻ High Blood Pressure	◻ High Cholesterol	◻ Migraines/Sinus Headaches	◻ Stroke
◻ Ulcer	◻ GERD/Reflux	◻ Diabetes	◻ Coronary Artery Disease	◻ Seizures
◻ Cancer	◻ Thyroid Disease	◻ Anxiety	◻ Right/Left Cataract Surgery	◻ Asthma
◻ Arthritis	◻ Depression	◻ Head Trauma	◻ COPD/Emphysema	◻ Anemia

◻ Other medical problems: _____

◻ Surgeries or Hospitalizations: _____

Review of symptoms (check all that apply):

1.	Constitutional	◻ Fevers	◻ Loss of appetite	◻ Night sweats	◻ Weight loss	◻ Weight gain
2.	Eyes	◻ Blurry vision	◻ Vision loss	◻ Double vision	◻ Redness	◻ Eye pain
3.	Ear, Nose, Throat	◻ Snoring	◻ Ringing in the ears	◻ Hearing loss	◻ Earache	◻ Sinus trouble
4.	Cardiovascular	◻ Palpitations	◻ Unable to lie flat	◻ Chest pain	◻ Fainting	◻ Legs swelling
5.	Respiratory	◻ Cough	◻ Shortness of breath	◻ Hay fever		
6.	Gastrointestinal	◻ Indigestion	◻ Nausea	◻ Vomiting		
7.	Genital/Urinary	◻ Incontinence	◻ Nighttime Urination	◻ Incontinence	◻ Urgency	◻ Frequent Urination
8.	Neurologic	◻ Sleepiness	◻ Tremors	◻ Headaches	◻ Dizziness	◻ Numbness
9.	Psychiatric	◻ Restless sleep	◻ Loss of consciousness	◻ Depression	◻ Forgetfulness	◻ Anxiety
10.	Allergy	◻ Hay fever	◻ Sinus headaches	◻ Hives		
11.	Endocrine	◻ Fatigue	◻ Hot/cold intolerance	◻ Irregular menses		
12.	Musculoskeletal	◻ Neck pain	◻ Back pain	◻ Leg pain	◻ Joint pain	◻ Osteoporosis
13.	Hematologic	◻ Easy bleeding	◻ Blood clots	◻ Blood transfusion		
14.	Sleep	◻ Restless legs	◻ Nocturnal choking	◻ Leg cramps	◻ Insomnia	

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Testing (check all that apply):

Have you had any of the following sleep lab tests?

Home Sleep Test ☐ Yes ☐ No If so, what/where/when? _____

Sleep Study ☐ Yes ☐ No If so, what/where/when? _____

CPAP ☐ Yes ☐ No If so, what/where/when? _____

Medications (list both prescription & over the counter) ☐ List attached

Medication name/strength	Times per day	Who prescribed

Medication allergies: ☐ None ☐ List _____

Social History (check all that apply):

Employment status: ☐ Retired ☐ Disabled ☐ Student ☐ Homemaker ☐ Unemployed
☐ Employed Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

I live: ☐ Alone ☐ With spouse ☐ With children ☐ With parents ☐ Own home
☐ Group home ☐ Assisted living ☐ Nursing home ☐ Senior apartment

Smoker ☐ No ☐ Yes _____ packs per day Date quit _____

Alcohol ☐ No ☐ Yes _____ drinks per day Date quit _____

Caffeinated Beverages ☐ No ☐ Yes _____ cups per day

Recreational Drugs ☐ No ☐ Yes What kinds and how often? _____

Exercise ☐ No ☐ Yes Type and how often? _____

Living Will ☐ No ☐ Yes ☐ Full Resuscitation ☐ Do not Resuscitate ☐ No Vent ☐ GenMedCare

Are you at risk for AIDS? ☐ No ☐ Yes

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Family History (check all that apply):

Do any of your immediate family members suffer from?

◻ Heart Disease	◻ High Blood Pressure	◻ High Cholesterol	◻ Migraine	◻ Stroke
◻ Dementia	◻ Parkinson's Disease	◻ Diabetes	◻ Muscle Weakness	◻ Seizures
◻ Cancer	◻ Thyroid Disease	◻ Multiple Sclerosis	◻ Attention Deficit	◻ Alzheimer's
◻ Alcoholism	◻ Sleep Apnea	◻ Restless Legs	◻ Learning Disorders	

Mother ◻ Living Age _____ ◻ Deceased Age _____

Father ◻ Living Age _____ ◻ Deceased Age _____

Authorization to speak to a family member ◻ No ◻ Yes Who? _____

Sleep History

What is your major sleep complaint(s)? _____

_____

How long have you had this/these problem(s)?

Duration _____weeks _____ months _____ years

Are you currently on ◻ CPAP ◻ BIPAP

If yes, what is your current pressure setting? _____

If yes, who supplied you with your equipment? _____

Are you currently on Oxygen? ◻ YES ◻ NO

If yes, how many liters are you currently using? _____

Have you been told that you stop breathing during sleep? ◻ Yes ◻ No ◻ Unknown

How do you feel upon waking? (Check all that apply)

◻ Dry mouth ◻ Headache ◻ Refreshed ◻ Unrefreshed ◻ Confused ◻ Covers messy ◻ Covers neat

1.	Do you ever have vivid dreams falling asleep?	◻ Never	◻ Occasional	◻ Frequent	◻ Always
2.	Do you sleepwalk?	◻ Never	◻ Occasional	◻ Frequent	◻ Always
3.	Do you ever have unusual movements in sleep?	◻ Never	◻ Occasional	◻ Frequent	◻ Always
4.	Do you sweat at night?	◻ Never	◻ Occasional	◻ Frequent	◻ Always

On weekdays I go to bed at _____ am/pm and wake up at _____ am/pm

On weekends I go to bed at _____ am/pm and wake up at _____ am/pm

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Do you take naps? □ Yes □ No (If yes, answer the next 5 questions)

1. For how long? _____
2. How many times per day? _____
3. How many times per week? _____
4. Do you wake up from naps feeling refreshed? □ Yes □ No
5. Are dreams present? □ Yes □ No

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling 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 television	_____
Sitting, inactive in a public place (e.g., 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	_____

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