Harrington Healthcare at Hubbard Sleep Lab
Medical History Form

In order to better understand your sleep problem, please accurately answer the following questions

Name: _____ Height: _____ Weight:_____ Date: _____

I am having a sleep study performed because of:

- ❑ Excessive fatigue/sleepiness
- ❑ Stopping breathing during sleep
- ❑ Insomnia (unable to sleep)
- ❑ Depression
- ☐ Snoring
- ☐ Legs jerking while sleeping
- ☐ Anxiety

Past Medical History (medical conditions, both physical and psychiatric):

_____

_____

Do you Currently have any **Allergies?** IF yes list:

_____

On a scale of 1 to 5 (with 5 being the most problematic) how much does sleepiness affect your:
Driving performance? 1 2 3 4 5 Work performance? 1 2 3 4 5

Have you had any driving accidents or 'near miss' incidents related to sleepiness? YES NO

How does your sleep problem affect your life and daily activities? _____
_____

Have you had any previous evaluations, examinations or treatment for this problem? _____ Yes ___
_____ No

If yes please describe _____

How likely are you to doze off or fall asleep in the following situations, 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 <u>most appropriate</u> number for each situation:

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

	Chance of Dozing
1. Sitting and reading	_____
2. Watching T.V.	_____
3. Sitting inactive in a public place (e.g. a theatre or meeting) .....…..	_____
4. As a passenger in a car for an hour with out a break .....…..	_____
5. Lying down to rest in the afternoon when circumstance permit ....…..	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after a lunch without alcohol	_____
8. In a car, while stopped for a few minutes in the traffic	_____

What are your usual working hours?_____ AM/PM to _____ AM/PM

On workdays:

I try to go to sleep at _____ AM/PM.

I wake up at _____AM/PM.

I get out of bed at _____ AM/PM.

When I am not working:

I go to sleep at _____ AM/PM.

I wake up at _____AM/PM.

I get out of bed at _____AM/PM.

Please list any prescribed or over the counter medications you are taking (can use back side too)

MEDICATION	DOSAGE (mg's)	FOR WHAT	HOW OFTEN

The following is a list of symptoms that may be experienced by people with sleep problems. Please mark those symptoms that you have experienced:

1.____ Creeping crawling sensation of legs before sleep

2.____ Dry mouth upon awakening

3.____ Taking more than 30 minutes to asleep on most nights

4.____ Sudden body weakness or buckling of the knees brought on by strong emotions

5.____ Headaches upon awakening

6.____ Feeling paralyzed when going to sleep

7.____ Waking up during the night and having a hard time falling back asleep

8.____ Walking while asleep

9.____ Disturbing dreams

10.____ "Restlessness of legs" when lying down before sleep

11.____ My family complains of My snoring

12.____ Forgetfulness or decreased concentration

13.____ Difficulty sleeping away From home

14.____ Sweating during the night

15.____ Seeing or hearing things w when trying to fall asleep

16.____ Waking up with a choking or gasping sensation

17.____ Nighttime panic attacks

18.____Nasal congestion discharge or obstruction at night

19.____ Bed Partner unable to sleep with you

20.____ Number of days a week you have these symptoms Days per week_____

On a typical day I drink:

_____ cups caffeinated coffee

_____ cups caffeinated tea

_____ glasses caffeinated soda

_____ glasses beer

_____ glasses wine

_____ glasses other alcohol

Do you drink any of the above 2 hours or less before going to sleep? ❑ Yes ❑ No

Have you had your tonsils taken out? _____ Yes _____ No

Please list any other surgeries you've had? _____

_____

Have you been hospitalized for other reasons? _____ Yes _____ No Why?_____

_____

Family history of sleep problems? _____ Yes _____ No

Family history of: **Heart Disease?** _____ Yes _____ No; **Stroke?** _____ Yes _____ No; **Cancer?** _____ Yes _____ No

Please have bed partner or other person who has seen you sleep answer the following:

1. How often do you see the patient sleeping? _____
2. What have you seen/heard?
   - ❑ Snoring lightly to loudly
   - ❑ Choking
   - ❑ Stop breathing
   - ❑ Moving/twitching of arms/legs
   - ❑ Grinding teeth
   - ❑ Sleep walking
   - ❑ Bedwetting
   - ❑ Sitting up while sleeping
   - ❑ Crying out while asleep
   - ❑ Awakens complaining of pain
   - ❑ Other: _____
3. Have you seen the patient fall asleep during day or evening activities or in a dangerous situation?
   ❑ Yes ❑ No

   If yes, describe: _____