National Jewish Health

New Patient Sleep Intake

Name: _____ Date of Visit: _____

Date of Birth: _____ Referring Physician and/or Other Physicians:

Primary Care Physician: _____ _____

_____

Retail Pharmacy: _____ Mail Order Pharmacy:_____

Address: _____ Mail Order Phone #:_____

_____

Phone #: _____

Preferred Laboratory: **Quest LabCorp Any**

Oxygen, CPAP, BiPAP

Supplier/Company: _____

Continuous or Pulsed (conserver) System: _____

Compressed Air (tanks) or Liquid: _____

How many Liters of oxygen? At Rest: _____ with Activity: _____ at Night: _____

How many hours per day? _____

Mask Type: _____ Settings: _____ Oxygen Bleed-in? Yes or No

	Medication Name	***Dose***	***Route (oral, Inhale)***	***How Often?***
1				
2				
3				
4				
5				
6				
7				
8				

Please list the medications that you have taken for your sleep problem:

1. _____
2. _____
3. _____
4. _____

Drug Allergies

Please list drug and medication allergies:

1. _____
2. _____
3. _____
4. _____

Vaccination/Immunization History

Date of last Immunizations (Month/Year)

Flu (Influenza) Shot: _____

High Dose Flu Shot: _____

Pneumovax (Pneumococcal Pneumonia) _____

Prevnar (Pneumococcal Pneumonia) _____

Chief Complaint

Please describe your chief complaint/s: _____

_____

_____

_____

_____

Sleep History

Do you currently experience any of the following: (please check all that apply

1. Excessive daytime sleepiness	Yes	No
2. Insomnia (difficulty falling asleep or staying asleep)	Yes	No
3. Frequent Snoring	Yes	No
4. Apneas (breathing holding during sleep)	Yes	No
5. Wake up gasping, choking or feeling short of breath	Yes	No
6. Excessive sweating during sleep	Yes	No
7. Headaches on awakening	Yes	No
8. Nighttime heartburn	Yes	No
9. Unpleasant sensations in your legs at night or at bedtime	Yes	No
10. Twitching or jerking of your legs during sleep	Yes	No
11. Losing muscle strength when laughing, excited or angry	Yes	No
12. Imagine seeing or hearing things as you fall asleep or wake up	Yes	No
13. Feeling unable to move (paralyzed) as you fall asleep or wake up	Yes	No
14. Unusual movements or behavior during sleep	Yes	No
15. Frequent disturbing dreams or nightmares	Yes	No
16. Sleepwalking	Yes	No
17. Teeth grinding or clenching	Yes	No
18. Incontinence or bedwetting	Yes	No

Sleep Schedule

	Weekdays	Weekends
1. Bedtime	_____	_____
2. Time it takes to fall asleep (minutes)	_____	_____
3. Wake time	_____	_____

4. Number of awakenings per night: _____
5. Average number of hours of sleep per night: _____
6. How do you feel when you wake? _____
7. Do you take naps during the day? **Yes** **No**

   If so, how long are the naps? _____

8. Do you shift work? **Yes** **No**

Childhood Sleep Disorder

Did you have any of the following as a child? (Please check all that apply)

1. Snoring Yes No
2. Sleep apnea Yes No
3. Insomnia Yes No
4. Excessive sleepiness Yes No

Family History

Do any of your family members experience the following sleep disorders: (Please check all that apply)

1. Snoring Yes No
2. Sleep apnea Yes No
3. Insomnia Yes No
4. Excessive sleepiness Yes No
5. Narcolepsy Yes No
6. Restless legs syndrome Yes No

Medical, Neurological or Psychiatric History

Please list health problems you have had:

1. Hypertension Yes No
2. Heart Failure Yes No
3. Abnormal cardiac rhythm Yes No
4. Heart Attack Yes No
5. Asthma Yes No
6. Chronic obstructive pulmonary disease Yes No
7. Gastroesophageal reflux Yes No
8. Diabetes Yes No
9. Thyroid disorder Yes No
10. Stroke Yes No
11. Seizures Yes No
12. Parkinson disease Yes No
13. Dementia Yes No
14. Head trauma Yes No
15. Depression Yes No
16. Anxiety disorder Yes No
17. Post-traumatic stress disorder Yes No

18. Attention deficit hyperactivity disorder Yes No
19. Other: _____ Yes No

Surgical History

Please circle the surgeries you have had:

1. Tonsillectomy – adenoidectomy Yes No
2. Nasal surgery Yes No
3. Sinus surgery Yes No
4. Palate surgery for sleep apnea Yes No
5. Gastric bypass surgery Yes No
6. Heart surgery Yes No
7. Other: _____ Yes No

Social History

Please circle one:

1. Marital status ☐Single ☐Married ☐Divorced ☐Widowed
2. Smoking: Yes No
   If yes, how much: _____ per day
3. Alcohol Use: Yes No
   If yes, how much: _____ per day
4. Caffeinated coffee: Yes No
   If yes, how much: _____ per day
5. Caffeinated tea: Yes No
   If yes, how much: _____ per day
6. Caffeinated soda: Yes No
   If yes, how much: _____ per day
7. Recreational Drugs: Yes No
   If yes, how much: _____ per day
8. Exercise: Yes No
   If yes, how much: _____ per day
9. Sleeping habits:
   ☐Sleep Alone ☐ Sleep with bed partner
   ☐Sleep with pet/s ☐ Sleep with children (co-sleeping)

Review of Systems

Please check all that has occurred over the previous 12 months:

Constitutional:

☐Weight Gain ☐Change in appetite

☐Weight Loss ☐Fatigue

Skin:

☐Rash ☐Eczema

Allergy-Immunology:

☐Seasonal allergies ☐Sneezing

Head-Eyes:

☐Headaches ☐Change in Vision

Ears-Nose-Throat:

☐Sinus symptoms ☐Nasal congestion

☐Nasal discharge ☐Nose bleeds

☐Sore throat ☐Hoarseness

☐Mouth breathing ☐Ear Pain

Lungs:

☐Shortness of Breath ☐Frequent Coughing

☐Wheezing ☐Chest Tightness

Heart:

☐Chest Pain ☐Palpitations

☐Heart failure ☐Sleep with more than 1 pillow

☐Waking up short of breath in the middle of the night

☐Leg Swelling

Gastrointestinal:

☐Gastric reflux ☐Heartburn

☐Abdominal Pain ☐ Abdominal bloating

Genito-urinary:

☐Bedwetting ☐ Frequent nighttime urination

Endocrine:

☐Cold intolerance ☐Heat intolerance

Musculoskeletal:

☐Arthritis ☐Fibromyalgia

☐Chronic Pain ☐Muscle weakness

Neurologic:

☐Seizures ☐Stroke

☐Memory Problems ☐Concentration Problems

Psychiatric:

☐Depressed mood ☐Mild Worry

☐Anxiety about health ☐Generalized anxiety

☐Post-traumatic stress disorder

☐Claustrophobia

Hematologic-Lymphatic:

☐Anemia ☐Bleeding

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?

This refers to your usual way of life in recent times. If you have not done some of these things recently, try to estimate how they might have affected you.

Use the following scale to rate your chance of dozing in the following situations:

Score 0 - Would never doze

1 - Slight Chance of dozing

2 - Moderate chance of dozing

3 - High chance of dozing

Situations	Score
Sitting and reading	_____
Watching TV	_____
Sitting, inactive, in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total Score	**_____**