1395 Commercial St. SE
Salem, Or 97302
503-990-7187 phone
503-990-7437 fax
Contact@salemsleepmedicine.com

Date: _____ email address:_____

First name: _____ Middle: _____ Last: _____

Address: _____Phone Number: _____

Ethnicity/Race (please circle): Black or African American Caucasian Hispanic or Latino Other _____

Preferred Language: _____Birth Date: _____Marital Status: ____Age:____Sex:_____

Pharmacy/Location: _____

Do you have Medicaid (Oregon Health Plan)? Yes _____ No _____

Referring Provider: _____ Primary Care Provider: _____

Reason for evaluation: _____

Please describe your main sleep problem(s): _____

How long have you been experiencing these problems? _____

Please describe in detail how fatigue or sleepiness affects you work/quality of life: _____

_____

Are you a shift worker on rotating shifts? _____ Swing Shift _____ Graveyard Shift _____

PREVIOUS SLEEP EVALUATION: Please circle YES or NO

Have you had a previous sleep study? YES / NO

If so, when and where? _____

Are you currently using CPAP, BiPAP or an oral appliance for sleep apnea? YES / NO

SLEEP PATTERN:

I usually go to bed around _____ o'clock.

It usually takes _____ minutes for me to fall asleep.

Once I fall asleep, I wake up _____times at night.

When I wake up it is to: (check all that apply):

- ❒ to urinate (_____ times at night).
- ❒ due to hot flash.
- ❒ Other_____.

When I try to fall asleep, I have racing thoughts through my mind. YES / NO

When I try to fall asleep, I have an irresistible urge to move my arms and/or legs to be comfortable. YES / NO

SLEEP BREATHING:

I have been told that I stop breathing while asleep. YES / NO

I wake at night choking or gasping for air. YES / NO

I have been told that I snore. YES / NO

I have been awakened by my own snoring. YES / NO

WAKE PATTERN:

I wake up around _____ AM / PM.

I usually feel refreshed when I wake up. YES / NO

I often experience morning headaches when I wake up. YES / NO

I have a dry mouth when I wake up. YES / NO

I feel okay initially, but need to go back to sleep after a few hours. YES / NO

I have experienced dreamlike images, hallucinations or sounds when falling asleep or when waking up. YES / NO

I have experienced sudden muscle weakness in response to laughter, anger, or surprises. YES / NO

I have experienced an inability to move when falling asleep or waking up YES / NO

DAYTIME SLEEPINESS:

I take daytime naps YES / NO

I have fallen asleep while driving YES / NO

Use the scale below and circle the appropriate number for each question. Add your total at the end.
0= no chance of dozing 1= mild chance of dozing 2= moderate chance of dozing 3= high chance of dozing

Sitting and reading something boring	0	1	2	3
Sitting inactive in a public place	0	1	2	3
Sitting in a passenger seat in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a nice lunch, without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
Watching TV	0	1	2	3

Total score_____

PAST MEDICAL HISTORY: (please circle YES or NO)

Allergies	YES/NO	Gallbladder disease	YES/NO
Anxiety	YES/NO	GERD	YES/NO
Arthritis	YES/NO	Headaches/Migraines	YES/NO
Asthma	YES/NO	Heart attack	YES/NO
Atrial fibrillation	YES/NO	Hypertension	YES/NO

Benign Prostatic hypertrophy	YES/NO	Irritable bowel syndrome	YES/NO
Cancer	YES/NO	Osteoporosis	YES/NO
Coronary artery disease	YES/NO	Renal disease	YES/NO
COPD	YES/NO	Seizure disorder	YES/NO
Depression	YES/NO	Stroke	YES/NO
Diabetes	YES/NO	Thyroid disease	YES/NO
Elevated lipids	YES/NO	Other_____	

SURGICAL HISTORY/YEAR:

_____ _____

_____ _____

MEDICATIONS: (Please include prescription, non-prescription, vitamins, minerals and herbs)

Name of Medication **Dosage** **Directions**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please use back of page to list additional medications

ALLERGIES TO MEDICATIONS:

Do you have any known drug allergies to medication? YES/NO

If so, please list below:

Name of allergen **Reaction experienced**

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY/HABITS: (please circle YES or NO)

Do you currently smoke cigarettes or use tobacco products? YES/NO
If yes, for how many years? _____ How many packs per day? _____
Have you ever tried to quit? YES/NO

Have you smoked in the past? YES/NO
If yes, for how many years? _____ How many packs per day? _____ Year quit: _____

Do you use caffeine? YES/NO
How many 8-oz beverages daily? Coffee _____Tea _____Soda _____

Do you drink alcohol? YES/NO
How many alcoholic beverages per week? Beer _____Wine _____Liquor _____

Do you use recreational drugs? YES/NO
Have you in the past? YES/NO
Do you have a medical marijuana card? YES/NO
Do you exercise? YES/NO What type? _____ How often: _____

FAMILY HISTORY OF SLEEP DISORDERS:

Sleep apnea Father _____ Mother _____
Brother _____ Sister _____
Other: _____

Restless leg syndrome Relation: _____
Narcolepsy Relation: _____

REVIEW OF SYSTEMS

Constitutional

Change in appetite YES / NO
Weight loss compared to 1 year ago _____ lbs. 5 years ago, _____ lbs.
Weight gain compared to 1 year ago _____lbs. 5 years ago, _____ lbs.

HEENT

Frequent headaches in the morning YES / NO

Difficulty of breathing through nose	YES / NO
Previous nose surgery	YES / NO

Respiratory

Cough for more than 2-4 weeks	YES / NO
Shortness of breath or wheezing	YES / NO
Asthma	YES / NO
COPD	YES / NO
Cough	YES / NO

Cardiovascular

Irregular or fast heartbeat	YES / NO
Swelling in feet or ankles	YES / NO
Fainting or passing out	YES / NO
Edema	YES / NO

Vascular

Leg Cramping	YES / NO

Gastrointestinal

Abdominal pain	YES / NO
Bloating	YES / NO
Frequent heartburn or indigestion	YES / NO
Difficulty swallowing	YES / NO
GERD	YES / NO

Genitourinary

Urinating more than 2x per night	YES / NO
Urinary incontinence	YES / NO

Metabolic/Endocrine

Abnormal sleep pattern	YES / NO
Change in sleep/wake pattern	YES / NO
Night sweating	YES / NO

Neurologic/Psychiatric

Sudden loss of vision, strength, or inability to speak	YES / NO
Headache	YES / NO
Dizziness	YES / NO
Seizures	YES / NO
Vertigo	YES / NO
Mood irritability	YES / NO

Anxiety	YES / NO
Depression	YES / NO

Musculoskeletal

Diffuse muscle pain	YES / NO

Hematologic

Unusual bruising or bleeding	YES / NO

Mobility

Falls due to poor balance/muscle weakness	YES / NO
Use of cane or wheelchair	YES / NO

INSOMNIA SEVERITY INDEX

For each question, please CIRCLE the number that best describes your answer. Please rate the CURRENT (last two weeks) severity of your insomnia problem(s).

Insomnia Problem	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How satisfied/dissatisfied are you with your current sleep pattern?

Very Satisfied Very Dissatisfied

0 1 2 3 4

5. How noticeable to others do you think your sleep problem is in terms of impairing your quality of life?

Not Noticeable Very Noticeable

0 1 2 3 4

6. How worried/distressed are you about your current sleep problem?

Not Worried Very Worried

0 1 2 3 4

7. What extent do you consider your sleep problem to interfere with your daily functioning, currently?

Not Interfering Very Interfering

0 1 2 3 4

Total Score (1+2+3+4+5+6+7) = _____

REM SLEEP BEHAVIOR DISORDER SCREENING

Have you ever been told, or suspected yourself, that you seem to ‘act out your dreams’ while asleep? For example, punching, flailing your arms in the air, making running movements, etc.

Yes _____

No _____