East Jefferson General Hospital
LCMC Health

EAST JEFFERSON GENERAL HOSPITAL
SLEEP LABORATORY
MEDICAL HISTORY & MEDICATION SURVEY

NAME:_____ **DATE:** _____
ADDRESS:_____
CITY, STATE, ZIP: _____
AGE:_____ **HOME PHONE:** _____ **BUS PHONE:**_____
OCCUPATION: _____ **M**____**F**_____
MARITAL STATUS:_____ **NUMBER OF CHILDREN** _____**AGES**_____

I. HEALTH STATUS

*1. What is your height?*_____ *inches*

*2. What is your weight?*_____ *pounds*

A. Has your weight changed in the last year? (+) _____ *(-)*_____ *pounds*

B. Has your weight changed in the last 4 months? (+) _____ *(-)*_____ *pounds*

3. What is your neck size? _____ *inches*

4. Are you in good health as far as you know? ☐ *Yes* ☐ *No*

5. Give the year of your last physical examination. _____
Abnormalities, if any _____

6. Have you had any health problems in these areas?

	TYPE OF PROBLEM	*DATES*	*PHYSICIAN, CLINIC OR HOSPITAL*
MENTAL HEALTH, DEPRESSION			
HEAD OR NERVOUS SYSTEM			
EARS, EYES, NOSE, THROAT, MOUTH OR SINUSES			
HEART, CIRCULATION, BLOOD PRESSURE			

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BREATHING, LUNGS			
STOMACH, DIGESTIVE			
URINE, KIDNEY OR SEXUAL			
OTHER (E.G., DIABETES, HORMONE ABNORMALITIES, HYPOGLYCEMIA)			
SURGICAL OPERATIONS			

7. How much of these beverages do you consume?

Coffee *Cups/day*_____ *Cups after 6:00 p.m.*_____

Decaffeinated Coffee *Cups/day*_____ *Cups after 6:00 p.m.*_____

Tea *Cups/day*_____ *Cups after 6:00 p.m.*_____

Carbonated Drinks *Cups/day*_____ *Cups after 6:00 p.m.*_____

Beer, Wine, Liquor *Cups/day*_____ *Cups after 6:00 p.m.*_____

*8. How many cigarettes, cigars or pipe-fulls of tobacco do you smoke?*_____ *day*

9. Do you smoke marijuana? ☐ *Yes* ☐ *No If yes, how often?*_____

10. Do you use non-prescription drugs? ☐ *Yes* ☐ *No Describe which and how much of each* _____

_____

11. Do you take any prescribed medication, either regularly or intermittently? ☐ *Yes* ☐ *No*

Name of Medication	*Dose*	*How Many Times Per Day*	*For What Reason*	*Length of times used*	*Prescribing Physician*

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12. *Name and address of personal or family physician*

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

14. *Family Health History*

	Living - Deceased	*Age*	*If deceased, what age*	*Cause of death*	*Medical Problems*
Father					
Mother					
Siblings (Indicate brother or sister)					

15. *Are you on home oxygen?* ☐ *Yes* ☐ *No* *If yes, what liter flow are you on?* _____

What type of apparatus do you use? (Nasal cannula, face mask, etc.)? _____

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EAST JEFFERSON GENERAL HOSPITAL
SLEEP LABORATORY
SLEEP HISTORY

NAME:_____ DATE:_____

1. Briefly describe your sleep problem: _____
   _____

2. Why are you being seen in the Sleep Lab now? _____
   _____

3. How long have you had this problem? _____ years?

4. How does this affect your life and daily activities? _____
   _____

5. How serious a problem is this for you?

   ☐ Not at all serious ☐ Moderately serious ☐ Very Serious

6. Have you had any previous evaluations, examinations, or treatment for this sleep problem or any other problem with your sleep? ☐ Yes ☐ No
   If so, briefly describe the evaluation, treatment and results below (include overnight pulse oximetry).
   _____
   _____

7. What was your sleep like as a child? _____

8. Did you sleep more, the same or less than other children? _____

9. When do you actually attempt to go to sleep and get out of bed weekdays?
   Go to bed _____ A.M/P.M. Get up _____ A.M./P.M.

10. When do you actually attempt to go to sleep and get out of bed weekends?
    Go to bed _____ A.M./P.M. Get up _____ A.M./P.M.

11. What is the average amount of sleep you need to feel alert and energetic?
    _____

12. On the average, how long does it take you to fall asleep at night after you turn out your bedroom lights? _____ minutes.

13. Has there been a recent change? ☐ Yes ☐ No
If yes, describe briefly: _____
_____

14. What do you do just prior to turning out the lights and attempting to go to sleep (e.g., reading, T.V., bath, etc.)? _____

15. Do you have a regular bed partner? ☐ Yes ☐ No

16. On the average, how many times do you wake up during the night? _____

17. Average number of minutes of each awakening. _____

18. Do you wake up too early in the morning and have trouble returning to sleep?
☐ Yes ☐ No

19. How do you ordinarily awaken? ☐ Spontaneously ☐ Alarm Clock ☐ Other

20. On the average, how long do you actually sleep at night?
_____ Hours Minutes _____

21. Is it difficult for you to awaken and get out of bed after sleeping? ☐ Yes ☐ No

22. Do you nap or return to bed after arising? ☐ Yes ☐ No
If yes, how many times per day? _____
Average length of sleep per nap _____ Hours _____ Minutes

23. Do you usually feel physically tired (separate from sleepy) during the day?
☐ Yes ☐ No

24. Are you bothered by sleepiness during the day? ☐ Yes ☐ No

Describe when and the extent _____
_____

25. Do you feel that you get too much sleep at night? ☐ Yes ☐ No
26. Do you feel that you get too little sleep at night? ☐ Yes ☐ No

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27. Do you find yourself falling asleep at inappropriate times? ☐ Yes ☐ No
If yes, describe _____

28. How long does the sleep episode last? _____ Hours _____ Minutes.

29. Do you feel rested or refreshed after the sleep episode? ☐ Yes ☐ No

30. Have you ever (a) fallen suddenly? ☐ Yes ☐ No
(b) experienced sudden bodily weakness? ☐ Yes ☐ No

31. Have you ever experienced a sense of weakness or paralysis upon:
A. Going to sleep? ☐ Yes ☐ No
B. How often does this occur? _____ times/week

32. Have you ever experienced seeing things or hearing voices or noises that may not be?
A. Upon going to sleep? ☐ Yes ☐ No
B. During the night? ☐ Yes ☐ No
C. Upon awakening ? ☐ Yes ☐ No
D. During the day? ☐ Yes ☐ No

33. Do you ever feel that you go into a dream immediately at the onset of sleep at night or when you nap? ☐ Yes ☐ No
If yes, briefly describe _____
_____

34. Have you been told that you snore while asleep? ☐ Yes ☐ No
Does this occur continuously through the night? ☐ Yes ☐ No

35. Is the snoring regular? ☐ Yes ☐ No
Is the snoring interrupted by gasping or choking? ☐ Yes ☐ No

36. Does the snoring disturb anyone?
A bed partner (or someone in the same bedroom)? ☐ Yes ☐ No
Someone in another room? ☐ Yes ☐ No
Sleep in house or apartment alone? ☐ Yes ☐ No

37. Has anyone ever told you that your arms or legs jerk or twitch while you are apparently asleep? ☐ Yes ☐ No
If yes, how often during the night does this occur? _____ times/night.
How many nights per week does this occur? _____ nights/week.
At what age did this first come to your attention? _____ years old.
Does this seem to awaken you from sleep? ☐ Yes ☐ No

38. While lying in bed before sleep or upon awakening, have you ever experienced a restlessness of legs, "nervous legs" or "creeping, drawing" sensation in legs? ☐ Yes ☐ No
How often does this occur? _____ times/week.

Does anything relieve the situation (e.g, getting out of bed, taking medication, massage, etc.)? ☐ Yes ☐ No If yes, what _____

What age did you first experience this? _____ years old.

39. At what time of day do you feel most alert and function at your best?
_____ A.M./P.M.

40. Do you follow a fairly regular bedtime schedule? ☐ Yes ☐ No
If no, describe _____
_____

41. How much does changing your bedtime affect your sleep?
☐ Very Little ☐ Somewhat ☐ Much

42. Do you now or have you ever done any of the following: (Check all that apply)

	Times/Week	Age It Began	Last Occurred	Treatment
Talk while apparently asleep				
Sleepwalk				
Grind teeth while apparently asleep				
Wet the bed during sleep				
Wake up screaming or seemingly afraid in the first 2 1/2 hours of sleep				

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	Times/Week	Age It Began	Last Occurred	Treatment
Have disturbing dreams				
Have chest pain at night				
Have wheezing at night				
Have unusual movements while apparently asleep				
Awaken during the night with headaches				
Have recurrent dreams				

43. Have you ever realized that you have done something without being aware of it at the time or not knowing how you came to be in a certain place? ☐ Yes ☐ No
If yes, please describe briefly _____

44. Has anyone in your family ever had any sleep problems? ☐ Yes ☐ No
If yes, please list the type of problem (e.g., trouble getting to sleep, bed wetting, etc.) and relationship to you.

Type of Problem	Relationship	Treatment

45. Have you used any medication (prescribed or otherwise) to help your sleep problem? ☐ Yes ☐ No If yes, list below:

Name	Amount	Frequency	When Used	Helpful	Prescribing Physician

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Sleep Disorders Program
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