THE LUNG CENTER

Sleep Disorders Specialists of Manatee
Michael D. Seeman, M.D. • Floyd W. Wells, M.D. • Michael W. Burke, M.D.

INITIAL SLEEP EVALUATION FORM:

Today's Date: _____

First Name: _____ Last Name: _____
Age: _____ Phone number :
Sex: ☐Male ☐Female
Race: ☐White ☐Black ☐Hispanic ☐Asian ☐Other: _____
Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widow
Education: ☐High school grad. ☐College grad.
Occupation: _____ ☐Retired ☐Disabled
Your usual work schedule: _____

Referring Physician's Name: _____
Full Address: _____ City/State/Zip: _____
Your Physician's Phone# :(___) _____

Your current MAIN SLEEP COMPLAINTS are:

☐Feeling sleepy most of the time ☐Snoring Loud
☐Difficulty falling sleep ☐Difficulty maintaining sleep
☐Other: _____
How long has this problem bothered you? _____months/years

PREVIOUS SLEEP EVALUATION

Name of Hospital/Sleep Center: _____ Location: _____
Approximate date of sleep study: _____
Diagnosis: _____
Previous Treatments: _____

Please mark all your MEDICAL CONDITIONS:

☐High Blood Pressure ☐Diabetes/ or High Blood Sugar
☐High Cholesterol ☐Thyroid diseases
☐Heart failure ☐Previous heart attack
☐Chest pains or Angina
☐Cardiac Arrhythmia : If known What Type? _____
☐Stroke
☐Persistent Headaches ☐Seizure/epilepsy
☐Asthma ☐COPD (chronic bronchitis or emphysema)
☐Reflux ☐Arthritis (joint pain)
☐Sinus trouble ☐Persistent congestion of nose
☐Cancer type & location_____ When diagnosed: _____
☐Depression ☐Anxiety disorder
☐Schizophrenia ☐Bipolar disorder
Please list your all other medical problems: _____
_____

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Sleep Related History

Please rate yourself by circling the number 1-7 that best describes the degree or frequency that you are bothered by a particular complaint or problem.

1	2	3	4	5	6	7
None	Very slight	Slightly	Moderate	Major	Great	Very great
Never	Rare	Seldom	Occasionally	Often	Very often	Always

Do you have or How often do you experience the followings?

1 2 3 4 5 6 7 **Loud snoring**
1 2 3 4 5 6 7 **Your bed partner sleep separately due to your snoring**
1 2 3 4 5 6 7 **Your bed partner note that you stop breathing**
1 2 3 4 5 6 7 **Waking up with breakthrough chocking/gasping**
1 2 3 4 5 6 7 **Dryness of throat on awakening**
1 2 3 4 5 6 7 **Headaches on awakening**

1 2 3 4 5 6 7 **Feeling unrested** even after adequate hours of sleep?
1 2 3 4 5 6 7 **Falling asleep while driving?**

1 2 3 4 5 6 7 **Paralysis (unable to move)** when just falling asleep or waking up
1 2 3 4 5 6 7 **Hallucinations (people, voices, or sounds)** in the room when just falling asleep or when awakening
1 2 3 4 5 6 7 **Sudden muscular weakness** with laughing, angry, or emotional situations
1 2 3 4 5 6 7 **Colorful** or **vivid dreams**

1 2 3 4 5 6 7 **Sleep walking**
1 2 3 4 5 6 7 **Unusual behaviors** during sleep:
Circle the type: **violent movement** **eating confusion** **screaming-out**
1 2 3 4 5 6 7 **Nightmare**
1 2 3 4 5 6 7 **Acting out to your dreams**
1 2 3 4 5 6 7 **Heartburn** or **stomach acid in the mouth**
1 2 3 4 5 6 7 **Grinding teeth while sleeping**
1 2 3 4 5 6 7 **Irresistible urge to move legs** in the evening /night
Circle the type: **aching** **crawling** **creepy** **restlessness**
1 2 3 4 5 6 7 **Legs kicking or twitch during sleep**

1 2 3 4 5 6 7 **Problem with attention** or **concentration**
1 2 3 4 5 6 7 **Problem with memory**
1 2 3 4 5 6 7 **Feeling of depression**
1 2 3 4 5 6 7 **Feeling of anxiety**
1 2 3 4 5 6 7 **Claustrophobia (fear of being in tight place)**
1 2 3 4 5 6 7 **Sexual dysfunction**

1 2 3 4 5 6 7 **Problem falling asleep**
1 2 3 4 5 6 7 **Racing thoughts at bedtime**
1 2 3 4 5 6 7 **Panic attack during sleep**

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Have you had **any change in weight over last 6months?**
If yes did you: ☐**Gain** ☐**Lost** **How much?** ____ **lb**
Do you do any exercise? ☐No ☐Yes->if yes what kind? _____
How often? ____ times per week for ____ hours. What time usually? _____am/pm

Epworth Sleepiness Scale:

*In contrast to just feeling tired, **how likely are you to doze off** or fall asleep in the following situations? 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	1	2	3
Never	**Slight chance**	**Moderate chance**	**High chance**

Sitting & reading	_____
Watching TV	_____
Sitting inactive in a public place (i.e. theatre)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting & talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopping for a few minutes in traffic	_____
total score:	_____

(normal: 1-7, mild: 8-11, moderate: 12-16, severe: 17-20, very severe:21-24)

Sleep Habits:

What time you usually **go to bed? Weekdays?**____pm/am **Weekends?**___pm/am
How long does it take for you to **fall asleep?** _____minutes
What time do you usually **get up? Weekdays?**_____pm/am **Weekends?**____pm/am
How many times do you **wake up** while sleeping? ____times
What is the **reason** usually you **wake up?** ☐Unknown ☐other: _____
Do you take **naps during day?** ☐No ☐ If yes **how often?**____times/day.
How **many minutes**? ____ min. **What time**? _____

Do you have a **TV/Radio in your bedroom?** ☐Yes ☐No
Do you **fall asleep easier in other places than your bed?** ☐ No ☐Yes, if so
Where ?_____
Do you have any **complaints related to your bedroom environment?** ☐No ☐Yes
Please explain: _____

Social History:

Have you been a smoker? ☐No ☐Yes _____ **packs per day** for _____ **years**
Have you quit smoking? ☐No ☐Yes How many years ago? _____
Do you drink alcohol? ☐No ☐Yes ___ drink per weeks
Do you use any illicit drug? ☐No ☐Yes->if yes what kind ? _____
Coffee: _____ cups per day. What time is your last drink prior to sleep? ___am/pm
Tea or Ice tea: _____ cups per day. What time is your last drink prior to sleep? ___am/pm
Caffeinated soda: _____ cans per day. What time is your last drink prior to sleep? ___am/pm

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Other Medical History & Review of Systems:

Do you have seasonal allergies? ☐ **No** ☐ **Infrequent** ☐ **Continuous**
Do you have sinusitis? ☐ **No** ☐ **Infrequent** ☐ **Continuous**
Do you have nasal congestion? ☐ **No** ☐ **Infrequent** ☐ **Continuous**
Have you had any history of broken nose? ☐ **No** ☐ **Yes**
Have any had any serious head injury? ☐ **No** ☐ **Yes**
Have you ever had seizures? ☐ **No** ☐ **active** ☐ **controlled on medication** ☐ **Past)**

Do you have any **family history of sleep disorder?** ☐ No ☐ if yes what kind?
Obstructive sleep apnea Narcolepsy Restless leg Syndrome (RLS) or PLM
Other: _____
Do you have any **known allergies to any medication?** ☐ No ☐ If yes: _____

Surgical History

Did you have your tonsils removed? ☐ **No** ☐ **Yes, if so what Age:** _____
Do you have dentures? ☐ **No** ☐ **upper teeth** ☐ **Lower teeth** ☐ **both upper & lower**
Other: _____

MEDICATIONS:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

STOP! THE REST TO BE FILLED BY THE SLEEP CLINIC STAFF

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