



Austin Sleep Disorders Center

Comprehensive Quality Care in Austin

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Name: _____ Date: ____ / ____ / ____

Gender: Male ____ Female ____ Age: ____ years Height: ____ ft ____ in.

Current Weight: ____ lbs Peak lifetime weight: ____ lbs Weight 5 years ago: ____ lbs

What is your primary sleep problem and its duration?

List other problems with sleep and their duration:

A) _____

B) _____

Have you ever had a sleep problem diagnosed in the past? Yes No

If yes, what is it and when was it diagnosed? _____

Have you ever had a sleep study in the past? Yes No

If yes, when and where was it done? _____

SLEEP HABITS

Answer the following questions based on your experience in the last six months, with "night" meaning your major sleep time:

On weekdays (workdays), what time do you usually: Go to bed? _____ AM PM
Get up? _____ AM PM

On weekends (non-workdays), what time do you usually: Go to bed? _____ AM PM
Get up? _____ AM PM

If you could set your own schedule, what time would you: Go to bed? _____ AM PM
Get up? _____ AM PM

Do you keep a fairly regular sleep/wake schedule? AM PM

Do you read, watch TV or eat in bed? AM PM

How many hours do you usually sleep? _____

Do you feel you get enough sleep at night? AM PM

Are you usually refreshed after a night of sleep? AM PM

NIGHTTIME SYMPTOMS

Do you often have trouble falling asleep at night? Yes No

How long does it usually take you to fall asleep at night? _____ Minutes/hours (circle one)

How many times do you usually wake up during the night? _____

Why do you wake up? _____

How long are these wakefulness periods when added together? _____ Minutes per night

Do you lie awake at night feeling depressed, worried, anxious or tense? Yes No

Do you wake from sleep suddenly feeling fear, anxiety or panic? Yes No

Is your sleep significantly different when you sleep away from home? Yes No

Have you ever used medication, hypnosis or relaxation therapy to help sleep? Yes No

Have you ever taken a prescription or over-the-counter drug to help your sleep? Yes No

If yes, describe: _____

- Do you have discomfort, unusual feelings or sensations in your legs (below knees) at night? Yes No
- If yes, is this sensation accompanied by urge to move legs? Yes No
- Is this sensation worse at rest and at least partially relieved by activity? Yes No
- Is this sensation worse in evening or at night than during day? Yes No
- Have you been told you move your legs a lot when you sleep? Yes No
- Are your bed covers messy when you wake up? Yes No
- Do you snore? Don't know Yes No
- If yes, is your snoring altered by body position? Yes No
- What is your preferred sleeping position? Back Side Stomach Other: _____
- Have you ever been told that you stop breathing during sleep? Yes No
- If yes, how often (circle one)? Nightly Weekly Monthly Less than monthly
- Do you wake up snorting, choking or gasping for air? Yes No
- Do you ever wake up with a sore throat or dry mouth? Yes No
- Have you been told you sleep walk? Yes No
- Have you been told you sleep talk? Yes No
- Have you even bitten your tongue during sleep? Yes No
- Have you ever had an episode of incontinence in sleep? Yes No
- Have you ever had seizures in sleep? Yes No
- Do you act out your dreams? Yes No
- Have your sleep time actions ever hurt yourself or others? Yes No
- Do you grind teeth at night? Don't know Yes No
- Do you ever have vivid dreams when falling asleep or waking up and sometimes are not sure if they are real? Yes No
- Have you ever experienced the feeling of being paralyzed when falling asleep or waking up? Yes No
- Do you feel unrefreshed no matter how much sleep you get? Yes No

DAYTIME SYMPTOMS

- Do you feel excessively sleepy during the day? Yes No
- If yes, how long? _____ Months/Years (circle one)
- Do you feel fatigued during the day? Yes No
- Have you ever had an accident or injury due to falling asleep driving? Yes No
- If yes, describe: _____
- When did it last occur? _____
- Do you nap during the day? Yes No
- If yes,
- | | Number of naps | Average length (minutes) |
|-------------------------|----------------|--------------------------|
| Weekdays (workdays) | _____ | _____ |
| Weekends (non-workdays) | _____ | _____ |
- Are your naps refreshing? Yes No
- Do you ever feel weak (legs, arms or jaw) with strong emotions? Yes No

Have you ever taken stimulants (Ritalin, amphetamines)? Yes No

If yes, why was this prescribed and when did you last take it? _____

CHILDHOOD SLEEP

Did you have any of the following problems during childhood? (Check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Sleep walking | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Night terrors |
| <input type="checkbox"/> Sleep talking | <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Difficulty waking up |
| <input type="checkbox"/> Daytime sleepiness | <input type="checkbox"/> Seizures/convulsions in sleep | <input type="checkbox"/> Head banging |
| <input type="checkbox"/> Tooth grinding | <input type="checkbox"/> School problems due to sleepiness | <input type="checkbox"/> Bed-wetting |

MEDICAL HISTORY

Do you have any of the following?:

- | | |
|---|--|
| <input type="checkbox"/> Heartburn, gastric reflux or hiatal hernia | <input type="checkbox"/> Asthma, emphysema or bronchitis |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Deviated nasal septum | <input type="checkbox"/> Broken nose |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Sinus problems | |
| <input type="checkbox"/> Other: _____ | |

Are you currently seeing a psychiatrist or psychologist? Yes No

If yes, for what reason? _____

If you are a woman, are you past menopause? Yes No

If yes, did your sleep change after menopause? Yes No

If yes, describe: _____

SURGICAL HISTORY

Have you ever had surgery on your nose or throat? Yes No

If yes, what is it and when was it done? _____

List all past surgeries and the year performed.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

FAMILY HISTORY

Indicate whether any of the following sleep disorders are present in your blood relatives by checking the box and listing the affected family member (e.g. sister, father).

- | | | |
|---------------------|--|--------------------------|
| Insomnia: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Affected relative: _____ |
| Daytime sleepiness: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Affected relative: _____ |
| Narcolepsy: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Affected relative: _____ |
| Night terrors: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Affected relative: _____ |

REVIEW OF SYMPTOMS

NAME: _____

DATE: _____

Please circle any of the problems, which you now have or have had within the past year:

GENERAL

- Weight changes
- Poor appetite
- Tiredness
- Fever or chills

HEAD & NECK

- Neck pains
- Sores in the mouth
- Headaches

EYES

- Loss of vision
- Double vision
- Blurring of vision
- Aversion to light
- Pain

ENT

- Hearing difficulty
- Ringing in the ears
- Earaches
- Allergies

HEART

- Palpitations
- Chest pain
- Sleeping upright to breathe
- Swelling in feet or ankles
- Fainting

LUNGS

- Wheezes
- Coughing
- Coughing up blood
- Shortness of breath

DIGESTION

- Heartburn
- Nausea/vomiting
- Difficulty swallowing
- Constipation

MUSCULOSKELETAL

- Bone or joint pain
- Joint stiffness & swelling
- Muscle tenderness
- Back pains

NEUROLOGICAL

- Seizures
- Loss of consciousness
- Loss of balance
- Numbness
- Loss of memory
- Speech problems

ENDOCRINE

- Excessive sweating
- Excessive thirst
- Excessive hunger

GENTOURINARY

- Frequent urination at night
- Brown or bloody urine
- Difficulty starting to urinate
- Impotence

PSYCHIATRIC

- Anxiety
- Depression

SKIN

- Rash
- Easy bruising

OTHER:
