SENTARA
eCare Health Network

Patient Label

ASSESS

Last Name: _____ First Name: _____ Middle Initial: ____

Primary doctor _____ Consultation Requested by_____

Current Problem or Reason for Referral:

_____

_____

These sleep issues have been going on for how many months_____years_____?
Have you seen a sleep doctor/NP/PA before? Y/N Are you a CPAP user? Y/N

Sleepiness (Epworth Sleepiness Scale)
In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? (Even 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 = would never doze; 1 = Slight chance of dozing; 2 = Moderate chance of dozing; 3 = High chance of dozing.

	Please circle the best answer				
Sitting and reading	0	1	2	3	
Watching T.V.	0	1	2	3	
Sitting inactive in a public place (i.e., theater)	0	1	2	3	
As a car passenger for an hour without a break	0	1	2	3	
Lying down to rest in the afternoon	0	1	2	3	
Sitting & talking to someone	0	1	2	3	
Sitting quietly after lunch without alcohol	0	1	2	3	
In a car, while stopped for a few minutes in traffic	0	1	2	3	Total _

Sleep Habits/Sleep Envirnoment
Please check all that apply.

- ☐ I sleep alone
- ☐ I sleep with someone
- ☐ Pets sleep in my bed
- ☐ I watch TV in bed
- ☐ I often look at the clock in bed
- ☐ I eat/drink chocolate
- ☐ I sleep on my back/side/stomach
- ☐ I have a bed partner with a sleep disorder
- ☐ I sleep on my stomach
- ☐ I read in bed
- ☐ I keep my bedroom cold/warm
- ☐ I take naps, if so how many? ____ / day

Number of pillows used when sleeping: ____ Do you sleep in a bed or chair? _____
How many times do you usally wake up during the night? _____
How many times do you wake up to use the bathroom during the night? _____
What do you do prior to going to bed? _____
Bedtime: On Weekdays? _____ On Weekends? _____
Waketime: On Weekdays? _____ On Weekends? _____
How long does it take for you to fall asleep? _____
How long does it take for you to go back to sleep when you wake up during the night?_____
Do you use an alarm to wake up? How often do you hit the snooze alarm? _____
How do you feel when you wake up? (circle one) Rested Tired

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Sleep History
Please check any symptoms you have experienced:

- ☐ Had an accident or near accident due to sleepiness or falling asleep? Drive drowsy at times?
- ☐ I hear, see for feel things that are not real when falling asleep
- ☐ I have sudden muscle weakness when I am excited, laughing or angry
- ☐ I sometimes wake up and am not able to move at all
- ☐ Morning Headaches
- ☐ Daytime napping
- ☐ Snoring
- ☐ I stop breathing during sleep
- ☐ Toss and Turn/Restless
- ☐ Grind Teeth
- ☐ Heartburn, chest pain or reflux
- ☐ Night Sweats
- ☐ Nightmares
- ☐ Bedwetting
- ☐ Sleepwalking/Sleeptalking
- ☐ Leg cramps/twitches/kick legs during sleep
- ☐ Unpleasant, restless feelings in legs or arms

Current Medications: Please list your current prescription and non-prescription medications.

Medication	**Dose**	**How often?**	**How long?**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Name drug(s) to which you are allergic_____
Latex Allergy? Y or N

Past Medical History (Check all that apply to you)

- ☐ Asthma
- ☐ Angina/Chest Pain
- ☐ Thyroid Disease
- ☐ Chronic Bronchitis
- ☐ Heart Attack
- ☐ Emphysema
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Stomach/Intestinal Ulcers
- ☐ Irregular Heartbeat
- ☐ Hepatitis/Liver Disease
- ☐ Pneumonia
- ☐ Depression
- ☐ Tuberculosis
- ☐ Hay Fever
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Anemia
- ☐ Parkinson's Disease
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Depression
- ☐ Dementia
- ☐ Bipolar Disorder
- ☐ Anxiety
- ☐ Migraine headaches

☐ Stroke ☐ Cancer Type/location: _____ ☐ Lung/Chest/HeartSurgery_____
☐ Other known medical problems: _____

Immunization:
Date of last flu vaccine _____ Date of last pnuemonia vaccine _____

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Past Surgical History (List operation and approximate year including surgeries for sleep disorders)

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

Family History

Please list the age and health problems of your family members. Please include any sleep problems or other illnesses they may have. If they are deceased, please list the age and cause of death.

Father: _____
Mother: _____
Brothers/Sisters: _____
Children: _____

Social History

Marital Status_____ Number of Children _____

Have you ever smoked? No Yes Still smoking? No Yes

When did you start smoking? _____ When did you quit? _____

How long would a pack last you? _____

What do you smoke? ___Cigarettes ___Cigars ___Pipe ___Chewing Tobacco ___Other

Do you drink any alcoholic beverages? No Yes

How much per day? _____ per week? _____

Do you drink any coffee ____ tea____ soda____ energy drinks____?

Do you currently use recreational drugs? No Yes

How often do you exercise? _____ / week What do you do for exercise?_____

Occupational History

What is your current occupation or position? _____

Dose your job involve shift work or night work? Y/N

If retired, what jobs or positions have you held? _____

Review of Systems

Height: _____ Weight: _____lbs Maximum weight: _____lbs.

Please circle any of the following that apply to you:

Const:	Fever, weight gain.
Eyes:	Change in vision. Wear glasses/contacts.
ENT:	Hearing loss, sinus problems/congestion, post nasal drip, nosebleeds, difficulty swallowing.
Cardiac:	Chest pain, Irregular heart beat, leg swelling, trouble breathing laying flat.
Resp:	shortness of breath, wheezing, coughing, bloodied or discolored sputum.
GI:	nausea, vomiting, diarrhea, constipation, blood in stool.
GU:	Difficulty urinating, burning, incontinence, frequent urination, bloodied urine, loss of sex drive, erectile dysfunction.
Msktl:	Joint pain, muscle pain.
Neuro:	Headaches, migraines, seizures, loss of consciousness, memory loss, weakness.
Heme:	Bruise easily.
Allergy:	Hay fever, food allergies.
Psych:	Change in mood, depressed feelings, anxious.