BCM
Baylor College of Medicine

Patient Name (First & Last): ______________________________

Technician Name: ____________________ Date: __________

Welcome to SDG. If this is your first time to this specialty clinic we would like for you to take time and fill out all the following forms to the best of your ability. Thank you for your cooperation. We are always glad to serve you.

SLEEP PROBLEMS CHECKLIST

Patient Name ___________________________ Referring Physician __________________________

Age _____Weight ______Height_____ Collar size ______ DOB: _________ Race: ______________

Phone Number __________________ Other contact number ____________________________________

Address ______________________________City, State, & Zip _________________________________

Current relationship status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Living with someone

What is your occupation? _________________________

What problem causes you to seek help? ____

How does this problem affect your life? ____

1. Check the box for each problem you CURRENTLY HAVE:

☐	Loud Snoring	☐	Teeth grinding during sleep
☐	Frequent awakenings at night	☐	Morning headaches
☐	Choking for breath at night	☐	Morning dry mouth
☐	Gasping during sleep	☐	Sleepwalking
☐	I've been told that I stop breathing when asleep	☐	Sleep terrors
☐	Restless sleep	☐	Tongue biting during sleep
☐	Awaken unrefreshed	☐	Bedwetting
☐	Crawling feelings in legs when trying to sleep	☐	Acting out dreams
☐	Fear of being unable to sleep	☐	Feeling paralyzed when falling asleep or waking up
☐	Fear of being unable to fall back to sleep after awakening at night	☐	Sudden weakness when laughing
☐	Laying in bed worrying when trying to sleep	☐	Uncontrollable daytime sleep attacks
☐	Waking too early in the morning	☐	Falling asleep unexpectedly
☐	Sleep talking	☐	Falling asleep at work
☐	Sweating a lot at night	☐	Falling asleep at school
☐	Waking up with heartburn	☐	Falling asleep while driving
☐	Nightmares	☐	Recent change in sleep schedule
☐	I use sleeping pills to help me sleep	☐	Shift work interfering with sleep
☐	Pain interfering with sleep. Where is the pain?	☐	Waking up to urinate
☐	I feel very sleepy during the day?	☐	

2. How would you rate your current general health? ☐ Very poor ☐ Poor ☐ Average ☐ Good ☐ Very good

3. If you smoke ….. ____ Yes ____ No
What is the most you ever smoked? ____________ If you quit, how long ago? _____________________

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Sleep Problems Checklist (Continued)

4. Check if you now have or in the past had the following?

Condition	Now	Past	Condition	Now	Past
Diabetes	☐ Now	☐ Past	Anemia	☐ Now	☐ Past
High Blood Pressure	☐ Now	☐ Past	Peptic Ulcers	☐ Now	☐ Past
Stroke	☐ Now	☐ Past	Acid Reflux (heartburn)	☐ Now	☐ Past
Heart Disease or CHP	☐ Now	☐ Past	Kidney Disease	☐ Now	☐ Past
Heart Attack	☐ Now	☐ Past	Thyroid Disease	☐ Now	☐ Past
Angina	☐ Now	☐ Past	Arthritis	☐ Now	☐ Past
Emphysema or COPD	☐ Now	☐ Past	Back Pain	☐ Now	☐ Past
Asthma	☐ Now	☐ Past	Head Trauma	☐ Now	☐ Past
Tuberculosis	☐ Now	☐ Past	Severe headaches	☐ Now	☐ Past
Other Lung Disease	☐ Now	☐ Past	Epilepsy (Seizures)	☐ Now	☐ Past
Nasal Allergies	☐ Now	☐ Past	Passing out spells (fainting)	☐ Now	☐ Past
Runny or Blocked Nose	☐ Now	☐ Past	Depression	☐ Now	☐ Past
Hormonal Problem	☐ Now	☐ Past	Anxiety Disorder	☐ Now	☐ Past
Urological Problem	☐ Now	☐ Past	Problems with alcohol	☐ Now	☐ Past
Prostate Problem	☐ Now	☐ Past	Problems with drugs	☐ Now	☐ Past

5. List your current average for each category below:

____________ Number of cigarettes smoked per day ____________Other tobacco used per day (pipefuls or cigars)

____________ Cups of regular coffee per day ____________ Cups of tea per day

____________ Cans of beer per day (12oz.) ____________Glasses of wine per day (3-4 oz.)

____________ Alcoholic drinks per day (1-2 oz. straight or mixed)

____________ Glasses of cola or other caffeinated beverages per day

6. Family Information

Do either of your **parents, brothers** or **sisters** (if applicable) have any major diseases or sleep disorders

If yes, please describe: ____

____

____

7. Please list hospitalizations.

Reason for Hospitalization	Date

8. Please give important details about your medical conditions.

____

____

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9. Restless Leg Questionaire/ Please answer all the questions below by checking yes or no:

☐ Yes ☐ No **Do you have a strong urge to move your legs which you may not be able to resist?** The need to move is often accompanied by uncomfortable sensations, such as creeping, itching, pulling, creepy-crawly, tugging, or gnawing.

☐ Yes ☐ No **Do your restless leg symptoms start or become worse when you are resting?** The longer you are resting, the greater the chance the symptoms will occur and the more severe they are likely to be.

☐ Yes ☐ No **Do your restless leg symptoms get better when you move your legs?** The relief can be complete or only partial but generally starts very soon after an activity. Relief persists as long as the motor activity continues.

☐ Yes ☐ No **Are your restless leg symptoms worse in the evening especially when you are lying down?** Activities that bother you at night do not bother your during the day.

10. EPWORTH SLEEPINESS SCALE

How **LIKELY** are you to **DOZE** off of **FALL ASLEEP** in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times.* even if you have not done some of these things recently, try to work out how they would have affected you. **Please check one box per line.**

****CHANCE OF DOZING OFF****

NEVER (0 pts)	RARELY (1 pt)	FREQUENTLY (2 pt)	ALWAYS (3 pt)	SITUATION:
☐	☐	☐	☐	Sitting and reading.
☐	☐	☐	☐	Watching TV.
☐	☐	☐	☐	Sitting, inactive in a public place (example, a theater or a meeting).
☐	☐	☐	☐	As a passenger in a car for an hour without break.
☐	☐	☐	☐	Lying down to rest in the afternoon when circumstances permit.
☐	☐	☐	☐	Sitting and talking to someone.
☐	☐	☐	☐	Sitting quietly after lunch without alcohol.
☐	☐	☐	☐	In a car, while stopped for a few minutes in traffic.

Total Epworth Score: _____ / 24 possible points

11. Have you ever had a Sleep Study before? ☐ Yes ☐ No

If yes, please indicate **where** and approximately **when**: ______________________________

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SLEEP DEVELOPMENT GROUP SCREENING QUESTIONNAIRE

Please provide the following information:

12. YOUR SLEEP SCHEDULE

Your bedtime on WEEKDAYS _______ a.m. or p.m.

Time you get up on WEEKDAYS _______ a.m. or p.m.

Your bedtime on WEEKENDS _______ a.m. or p.m.

Time you get up on WEEKENDS _______ a.m. or p.m.

Do you nap? ☐ Yes ☐ No

How often do you nap? ________________ times per week.

How long are your naps? ________________ minutes.

Do you feel rested and refreshed? ☐ Yes ☐ No

Are you a shift worker? ☐ Yes ☐ No

If yes, what kind of shift do you work?

Do you currently use a CPAP or Bi-Level machine at home? ☐ Yes ☐ No

What are your current pressure settings? ____________ cm.

Are you on home oxygen? ☐ Yes ☐ No Settings:_____________ liters per minute.

How long have you been on home oxygen? ______________

Do you use the oxygen for sleep only? ☐ Yes ☐ No

Do you use the oxygen regularly or only when sick or short of breath? __________________________

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13. ☐ I am allergic to the following:
☐ Acetone ☐ Collodion ☐Tape ☐Other adhesives ☐ Latex ☐Gold/Silver Alloys ☐Alcohol
☐ Medications: ______________________________
☐ I have no known allergies

14. Sleep Development Group Medication Questionnaire

We need to know what drugs, vitamins, and herbal substances you have taken in the past 6 months. Please complete the form below. Check your medicine cabinet and your medical records for drugs. Think back about the health problems you have had and the medicines you took for them.

Name of drug, vitamin, or herbal substance used	Dose	# of pills	Taken for how long	Taken for what problem	Still Taking	
					YES	NO