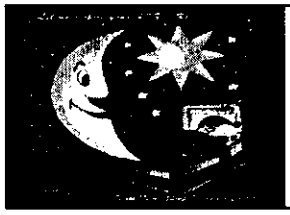
1-22-2017



Southlake Neurology and Sleep Wellness Clinic, PLLC
321 W. Southlake Blvd, Suite 180
Southlake, Texas 76092
Phone: (817) 421-2905, Ext 309 Fax: (817) 416-7284

Sleep History

Name:_____ DOB: _____

Referring Dr's Name_____
What is your primary sleep complaint?
For how long?
Do you have a secondary sleep complaint?
Have you ever been diagnosed with sleep disorder?
If yes please explain:

About what time do you go to bed?
About what time do you wake up?
How long does it take for you to fall asleep?
How often do you wake up during the night?
Do you feel rested in the morning upon awakening? If not please explain
How much sleep do you get at night?

Sleep Disordered Breathing
Do you snore? If yes please describe your snoring:
Do you wake yourself up from snoring?
Does your snoring disturb your partner? If yes please describe:
Do you have dry mouth at night?
Do you sweat at night? If yes how significant is your sweating:
Do you toss and turn at night?
Do you wake your partner up?
Do you gasp, choke, or snort at night?
Did anyone ever to tell you that you stop breathing during the night?
If yes please describe what they have witnessed:
Do you have any additional information that you want to add?

Restless Leg syndrome/periodic limb movement disorder of sleep
Do you have the urge to move your legs or arms in the evening or any part of the day? If yes please describe:

Do you have abnormal sensation in your feet or legs in the evening?
Do you have numbness or tingling in your feet?
Does your abnormal sensation or urge resolve with stretching of the muscles or walking?

Do any of your limb symptoms prevent you from going to sleep?
Do you move your limbs during the night in sleep?

Are you restless during the night? If you are please describe:
Is there a family history of restless leg syndrome? If yes please explain:
Have you ever been told that you have anemia? If yes what kind?

Other symptoms:
Do you have heart palpitations at night?
Do you wake up with heartburn?
Do you wake up with air hunger?
Do you have frequent urge to urinate?
Do you have shortness of breath or chest tightness at night?
Do you cough during the night?
Do you walk in you sleep or perform other activities in your sleep?
Do you talk in your sleep?
Do you grind your teeth?

Narcolepsy:
Do have excessive sleepiness during the daytime? If yes please explain:
Do you tend to doze off during the day?
Do you have tendency to doze off or feel significantly sleepy while driving?
Do you require naps in the daytime?
Do you feel better after a nap?
Do you ever have attacks where you feel weaker all over or just part of your body when you are anxious, excited, when laughing, or when you receive a bad news? Please explain in detail:

Do you have "sleep paralysis" when you doze off, about to go to sleep, or upon awakening?

Right after you fall asleep do you have vivid dreams?
Do you ever act out your dreams?

If you are sleepy or tired in the daytime, how does it affect your work or activities of daily living? Please explain in detail:

How does your sleep problem affect your daily life?

Do you have any other following? (The circle all those apply)

Anxiety depression lack of energy lack of desire to do anything lack of interest in pleasureful routines or hobbies lack of sexual desire mood swings memory loss other cognitive impairment irritability nighttime hallucinations or delusions

Please go to the next page for Epworth sleepiness scale:

1-22-2017

Please list your medical problems below:

1.
2.
3.
4.
5.
6.
7.
8.

Medication you take (Please highlight the ones you take for sleep)

1.
2
3.
4.
5.
6.
7.
8.
9.
10.

Do you have a pacemaker, vagal nerve stimulator, or deep brain stimulator?

Do you smoke? If yes how much and how long you have been smoking?

Do you drink? If yes how much and how long you've been drinking?

Is there anything else that you like to add about your sleep, your medical condition, or your special-needs? Please feel free to write below:

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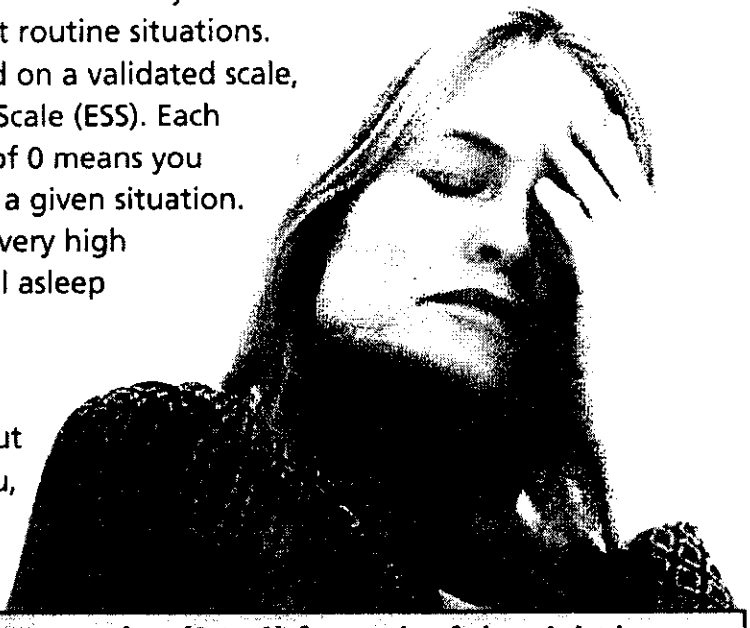
Do you suffer from excessive sleepiness?

The following questionnaire will help you measure your general level of sleepiness. Please rate the chance that you would doze or fall asleep during different routine situations. Answers to the questions are rated on a validated scale, known as the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3. A score of 0 means you would never doze or fall asleep in a given situation. A score of 3 means that there is a very high chance that you would doze or fall asleep in that situation.



Even if you haven't done some of these activities recently, think about how they would have affected you, and about whether or not you may have dozed or fallen asleep.

It is important that you choose a number (0 to 3) for each of the eight boxes.

Use this 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

Situation	Chance of dozing (0 to 3)			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place—for example, a theater or meeting	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3
Total Score				

Please turn the page over for an explanation of your score.

STOP-Bang Questionnaire

1. ***S***noring: Do you snore loudly (loud enough to be heard through closed doors)?
   Yes No
2. ***T***ired: Do you often feel tired, fatigued, or sleepy during daytime?
   Yes No
3. ***O***bserved: Has anyone observed you stop breathing during your sleep?
   Yes No
4. Blood ***P***ressure: Do you have or are you being treated for high blood pressure?
   Yes No
5. ***B***MI: BMI more than 35 kg/m^2?
   Yes No
6. ***A***ge: Age over 50 years old?
   Yes No
7. ***N***eck circumference: Neck circumference greater than 40 cm?
   Yes No
8. ***G***ender: Male?
   Yes No

High risk of OSA: Yes to 3 or more questions

Low risk of OSA: Yes to less than 3 questions

Chung F et al. *Anesthesiology* 2008;108:812-21.