Washington University in St. Louis Physicians

Name _____

Birthdate ___/___/_____

Visit Date ___/___/_____

Sleep Medicine *New Patient H & P Form*

PRESENT CONDITION AND/OR REASON FOR THIS APPOINTMENT

Why are you coming to see the doctor today? _____

How long have you had this problem? _____

Have you seen another doctor for this problem? ☐ No ☐ Yes

SLEEP HISTORY

Do you have or has anyone noticed that you have the following symptoms? (check all that apply)

☐ Snore
☐ Have restless sleep
☐ Talk in sleep
☐ Walk in sleep
☐ Have creeping or crawling in legs
☐ Stop breathing while sleeping
☐ Have morning headaches
☐ Take medicine for sleep
☐ Have leg jerks
☐ Feel like you have to move your legs
☐ Wake up gasping for air
☐ Acting out your dreams
☐ Have vivid dreams
☐ Have night time wheezing
☐ Can't lie down flat

Have you ever had a Sleep Study before? ☐ No ☐ Yes If yes, when? _____

Have you ever felt weak in your muscles when laughing, surprised, angry, or any other emotion? ☐ No ☐ Yes

Have you ever seen or heard things that aren't there while falling asleep or while waking up from sleep? ☐ No ☐ Yes

Have you ever felt like you cannot move while falling asleep or while waking up from sleep? ☐ No ☐ Yes

What is your typical Sleep Schedule:

on work days? Bedtime_____ Rise time _____ How long to fall asleep?_____

on off days? Bedtime_____ Rise time _____ How long to fall asleep?_____

Are you: sleepy during the day? ☐ No ☐ Yes fatigued during the day? ☐ No ☐ Yes

How many times do you wake up during the night? _____ For restroom visits? ☐ No ☐ Yes

How long does it take to fall back asleep? _____ minutes / _____ hours

If you have difficulty falling asleep, what do you do? _____

Is your nighttime sleep refreshing? ☐ No ☐ Yes

Do you take naps? ☐ No ☐ Yes If yes _____

How many days per week do you nap?_____ How long are your naps? _____ minutes / _____ hours

Are they refreshing? ☐ No ☐ Yes Do you dream during the naps? ☐ No ☐ Yes

EPWORTH SLEEPINESS SCALE

Estimate your risk of falling asleep in the following situations, using the scale below.

SITUATION	CHANCE OF DOZING
Sitting and Reading	☐ 0 = none ☐ 1 = slight ☐ 2 = moderate ☐ 3 = high
Watching TV	☐ 0 = none ☐ 1 = slight ☐ 2 = moderate ☐ 3 = high
Sitting inactive in a public place (e.g. theatre or meeting)	☐ 0 = none ☐ 1 = slight ☐ 2 = moderate ☐ 3 = high
As a passenger in a car for an hour without a break	☐ 0 = none ☐ 1 = slight ☐ 2 = moderate ☐ 3 = high
Lying down to rest in the afternoon when circumstances permit	☐ 0 = none ☐ 1 = slight ☐ 2 = moderate ☐ 3 = high
Sitting and talking to someone	☐ 0 = none ☐ 1 = slight ☐ 2 = moderate ☐ 3 = high
Sitting quietly after a lunch without alcohol	☐ 0 = none ☐ 1 = slight ☐ 2 = moderate ☐ 3 = high
In a car, while stopped for a few minutes in traffic	☐ 0 = none ☐ 1 = slight ☐ 2 = moderate ☐ 3 = high

CHECK BOX IF YOU HAVE OR HAD ANY OF THE FOLLOWING

☐ Stroke or TIA
☐ Seizures
☐ Kidney disease
☐ Nasal or sinus problems
☐ High blood pressure
☐ Drug or alcohol addiction
☐ Lung disease
☐ Depression
☐ Diabetes
☐ Heart disease
☐ Thyroid problems
☐ Neurological disease

TURN PAGE OVER & COMPLETE THE OTHER SIDE ▶

Name _____

Birthdate ___/___/___

Visit Date ___/___/___

PAST OR CURRENT MEDICAL PROBLEMS

_____

_____

_____

PAST SURGERIES

_____

_____

_____

ALLERGIES

Medicine	Reaction	Medicine	Reaction

MEDICATIONS

Medication	Dose	Medication	Dose

FAMILY HISTORY

Is there anyone in your family with any of the following conditions:

☐ Seizures ☐ Insomnia ☐ Parkinson's Disease ☐ High blood pressure ☐ Diabetes
☐ Dementia ☐ Sleep Apnea ☐ Excessive Sleepiness ☐ Coronary Artery Disease ☐ Narcolepsy

Is there someone in your family with an illness similar to the one for which you are seeing the doctor today?

_____

PERSONAL HISTORY

Education Level and Degree(s) _____ Occupation _____

Marital Status_____ With whom do you live?_____

Do you currently smoke? ☐ No ☐ Yes Did you used to smoke? ☐ No ☐ Yes If yes, when did you quit? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, how many drinks per week? _____

Do you currently use recreational drugs? ☐ No ☐ Yes

Do you have a history of using recreational drugs? ☐ No ☐ Yes

Do you drink coffee, caffeinated sodas, energy drinks or teas? ☐ No ☐ Yes If yes, how many cups per day? ____

Do you exercise regularly? ☐ No ☐ Yes How many days per week? _____

REVIEW OF SYSTEMS Only indicate problems occurring in the last 2 weeks.

General:
☐ Fevers or sweats
☐ Weight gain or loss _____ lbs

Neurologic:
☐ Passing out
☐ Numbness or tingling
☐ Headache

Psychiatric:
☐ Depression
☐ Anxiety
☐ Stressful life event

Ear, Nose, Throat:
☐ Sinus congestion

Respiratory:
☐ Trouble breathing
☐ Coughing or wheezing

Musculoskeletal:
☐ Back pain
☐ Muscle aches or cramps
☐ Joint pain

Genitourinary:
☐ Frequent urination

Cardiovascular:
☐ Chest discomfort
☐ Rapid or skipped heartbeats

Endocrine:
☐ Heat or cold intolerance
☐ Menopausal symptoms
☐ Thyroid problems

Gastrointestinal:
☐ Nausea or vomiting
☐ Heartburn

If you are NOT currently having any of the problems listed above, check here: ☐