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SLEEP HISTORY

NAME: _____ SSN: _____
 AGE: _____ HEIGHT: _____ WEIGHT: _____
 MARITAL STATUS: _____ RACE: _____ SEX: _____
 OCCUPATION: _____
 WHY WERE YOU REFERRED TO US? _____

 REFERRING PHYSICIAN: _____
 PRIMARY CARE PHYSICIAN: _____

1. Have you ever had a sleep evaluation or overnight sleep study done before? _____ If yes, please give the date and location _____

2. Please list any surgical procedures you have had.

3. Please list any current medical problems.

4. Please list all medications that you are currently taking or that have been discontinued within the last month. Include both prescription and over-the-counter medications.

Medication	Dosage	Medication	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Do you use tobacco products? _____ If yes, what type and what quantity do you use daily. Type: _____ Amount: _____

6. From the following list, please answer with the amount you consume per day.
Coffee: _____ Tea: _____ Soft drinks: _____ Alcohol: _____

7. Do you work nights or rotating shifts? If yes, please indicate the hours that you work.
Sun _____ Mon _____ Tue _____ Wed _____ Thu _____ Fri _____ Sat _____

8. Please describe in your own words the nature of the sleep problem that you are having.

9. *When you work*, what is your normal bedtime? _____
What time do you wake up? _____
When you are off, what is your normal bedtime? _____
What time do you wake up? _____

10. What do you normally do the last hour of the day before you go to sleep for the night?

11. Do you have a hard time falling asleep at night? _____

12. Do you have difficulty sleeping if lying flat? _____

13. Do you sleep well once you fall asleep? _____

14. Do you wake during the night? _____
How often: _____
Why: _____
What time(s): _____

15. Do you get enough sleep? _____ If not, why: _____

16. Do you have trouble concentrating during the day? _____

17. Have you had a car accident or near miss because of sleepiness? _____

18. Have you gained weight in the last year? _____ How much? _____

19. Have you had surgery for sleep apnea? _____ Which operation? _____
_____ When? _____
Did it help? _____ Any side effects? _____

20. Have you used nasal CPAP or BiPAP? _____
When? _____ Settings: _____

21. Do you use home oxygen? _____ Setting: _____ liters/minute

22. Have you ever been treated for depression? _____

23. Using the following scale, please circle the rating of the following questions as they pertain to your situation. **0=never 1=rarely 2=occasionally 3=frequently 4=constantly**

- | | | | | | |
|---|---|---|---|---|---|
| A. Do you snore? | 0 | 1 | 2 | 3 | 4 |
| B. Have you been told that you stop breathing in your sleep? | 0 | 1 | 2 | 3 | 4 |
| C. Do you wake with a headache? | 0 | 1 | 2 | 3 | 4 |
| D. Do you sweat heavily during the night? | 0 | 1 | 2 | 3 | 4 |
| E. Are you excessively sleepy after you have wakened? | 0 | 1 | 2 | 3 | 4 |
| F. Are you excessively sleepy later in the day after awakening? | 0 | 1 | 2 | 3 | 4 |
| G. Do you fall asleep in situations where you try to stay awake? | 0 | 1 | 2 | 3 | 4 |
| H. Do you fall asleep while driving? | 0 | 1 | 2 | 3 | 4 |
| I. Do you fall asleep while at work? | 0 | 1 | 2 | 3 | 4 |
| J. Do you have difficulty falling asleep once you go to bed for the day? ---- | 0 | 1 | 2 | 3 | 4 |
| K. Do you wake during the night and find it difficult to go back to sleep? --- | 0 | 1 | 2 | 3 | 4 |
| L. Do you experience vivid dreams upon falling asleep or awakening? ---- | 0 | 1 | 2 | 3 | 4 |
| M. Do you feel paralyzed or unable to move while in bed? | 0 | 1 | 2 | 3 | 4 |
| N. Do you feel a sudden weakness as if you might fall during laughter or anger? 0 | 1 | 2 | 3 | 4 | |
| O. Do you feel refreshed after a 15-20 minute nap during the day? | 0 | 1 | 2 | 3 | 4 |
| P. Do you wet the bed? | 0 | 1 | 2 | 3 | 4 |
| Q. Have you been told that you grind your teeth in your sleep? | 0 | 1 | 2 | 3 | 4 |
| R. Do you have crawling sensations or feel you have to move your legs in bed? 0 | 1 | 2 | 3 | 4 | |
| S. Have you been told that you kick your legs while you sleep? | 0 | 1 | 2 | 3 | 4 |
| T. Do you sleepwalk? | 0 | 1 | 2 | 3 | 4 |
| U. Do you talk in your sleep? | 0 | 1 | 2 | 3 | 4 |
| V. Do you sit up or scream in your sleep and not remember when you awaken? 0 | 1 | 2 | 3 | 4 | |

24. Do you have any food or medication **allergies**? _____.

