

**St. Joseph Hospital Sleep Disorders Center**

**700 Broadway**

**Fort Wayne, IN 46802**

**Office 260-425-3552 Fax 260-425-3553**

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NAME: \_\_\_\_\_ TELEPHONE: (HOME) \_\_\_\_\_

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ADDRESS: \_\_\_\_\_ TELEPHONE: (WORK) \_\_\_\_\_

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(CITY) \_\_\_\_\_ (STATE) \_\_\_\_\_ (ZIP CODE) \_\_\_\_\_

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FAMILY PHYSICIAN \_\_\_\_\_  
(NAME)

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(CITY) \_\_\_\_\_ (STATE) \_\_\_\_\_ (ZIP CODE) \_\_\_\_\_



My main sleep complaint is:

- I have trouble sleeping at night.
- I am sleepy all day.
- I have unwanted behaviors when I am asleep.

Explain:

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Current medical conditions that I am being treated for are:

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<p><b><u>DRUG ALLERGIES</u></b></p> <p><input type="checkbox"/> No Know Drug Allergies</p> <p><input type="checkbox"/> Aspirin</p> <p><input type="checkbox"/> Penicillin</p> <p><input type="checkbox"/> Codeine</p> <p><input type="checkbox"/> Sulfa</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Type of reaction _____</p>	<p><b><u>LATEX ALLERGIES</u></b></p> <p><input type="checkbox"/> No Known Allergies</p> <p><input type="checkbox"/> No Apparent Sensitivity</p> <p><input type="checkbox"/> <u>Known</u> Latex Allergy</p> <p><input type="checkbox"/> Reaction to Balloons</p> <p><input type="checkbox"/> Food: Avocados/Bananas/Chestnuts/Kiwi</p> <p><input type="checkbox"/> Other _____</p>	<p><b><u>MEDICAL HISTORY</u></b></p> <p><input type="checkbox"/> Confusion/Dementia</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> CVA/TIA</p> <p><input type="checkbox"/> Angina</p> <p><input type="checkbox"/> CHF</p> <p><input type="checkbox"/> Phlebitis, Varicose Veins</p>
<p><b><u>FOOD ALLERGIES</u></b></p> <p><input type="checkbox"/> No Known Food Allergies</p> <p><input type="checkbox"/> Milk/Milk Products</p> <p><input type="checkbox"/> Eggs</p> <p><input type="checkbox"/> Yeast</p> <p><input type="checkbox"/> Nuts</p> <p><input type="checkbox"/> Shell Fish</p> <p><input type="checkbox"/> Gluten/Wheat</p> <p><input type="checkbox"/> MSG</p> <p><input type="checkbox"/> Chocolate</p> <p><input type="checkbox"/> Strawberries</p> <p><input type="checkbox"/> Tomatoes</p> <p><input type="checkbox"/> Soy</p> <p><input type="checkbox"/> Orange Juice/Oranges</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Type of reaction _____</p>	<p><b><u>ENVIRONMENTAL ALLERGIES</u></b></p> <p><input type="checkbox"/> No Known Allergies</p> <p><input type="checkbox"/> Animal Dander (dogs, cats)</p> <p><input type="checkbox"/> Chemicals (describe: _____)</p> <p><input type="checkbox"/> Detergent</p> <p><input type="checkbox"/> Dust</p> <p><input type="checkbox"/> Iodine</p> <p><input type="checkbox"/> Mold/Mildew</p> <p><input type="checkbox"/> Sneezing/Runny Nose/ Watery Eyes</p> <p><input type="checkbox"/> Staples</p> <p><input type="checkbox"/> Tape</p> <p><input type="checkbox"/> X-Ray Dye</p> <p><input type="checkbox"/> Other _____</p>	<p><input type="checkbox"/> Thyroid Problems</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> COPD</p> <p><input type="checkbox"/> Diabetes (IDDM____ NIDDM____)</p> <p><input type="checkbox"/> GYN Problems</p> <p><input type="checkbox"/> Pregnant</p> <p><input type="checkbox"/> Prostate Problems</p> <p><input type="checkbox"/> Hepatitis (Type:_____)</p> <p><input type="checkbox"/> Kidney Problems</p> <p><input type="checkbox"/> Previous Blood Transfusions (Date:_____)</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> TB</p> <p><input type="checkbox"/> GI Problems</p> <p><input type="checkbox"/> Diverticulitis</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Problems with Anesthesia</p>

<p><b><u>MEDICAL HISTORY Cont.</u></b></p> <p><input type="checkbox"/> MRSA</p> <p><input type="checkbox"/> VRE</p> <p><input type="checkbox"/> HIV</p> <p><input type="checkbox"/> Recent exposure to a communicable disease</p> <p><input type="checkbox"/> Pertussis</p> <p><input type="checkbox"/> Chicken Pox</p> <p><input type="checkbox"/> STDs</p> <p><input type="checkbox"/> Other _____</p>	<p><b><u>SMOKER</u></b></p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><b><u>TOBACCO USE</u></b></p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> Have Quit</p> <p><input type="checkbox"/> Cessation Date: _____</p> <p><input type="checkbox"/> Chewing Tobacco</p> <p><input type="checkbox"/> Number of years: _____</p>	<p><b><u>SLEEP HABITS</u></b></p> <p>On weekdays (work days) I usually go to bed at: _____</p> <p>On weekdays I wake up at: _____</p> <p>I take a nap about _____ days each week.</p> <p>The amount of time that I usually take to fall asleep is: _____</p> <p>The number of times that I usually wake up during the night is: _____</p>
<p><b><u>CANCER MEDICAL HISTORY</u></b></p> <p><input type="checkbox"/> No History</p> <p><input type="checkbox"/> Patient has had cancer</p> <p><input type="checkbox"/> Parent with cancer (Type: _____)</p> <p><input type="checkbox"/> Sibling with cancer (Type: _____)</p> <p><input type="checkbox"/> Family member with cancer (Type: _____)</p> <p><input type="checkbox"/> Other _____</p>	<p><input type="checkbox"/> Age started _____</p> <p><input type="checkbox"/> Packs per day _____</p> <p><input type="checkbox"/> Other _____</p> <p><b><u>SUBSTANCE ABUSE</u></b></p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Substance Abuse _____</p> <p><input type="checkbox"/> Street Drugs _____</p> <p><input type="checkbox"/> Alcohol _____</p> <p><input type="checkbox"/> Recreational Drugs _____</p> <p><input type="checkbox"/> Other _____</p>	<p>When I wake up during the night, the time it usually takes me to fall asleep again is: _____</p> <p><b><u>Place a check beside any of the following statements that are true of you:</u></b></p> <p><input type="checkbox"/> I have a job that involves shift work or night work</p> <p><input type="checkbox"/> I frequently travel across time zones (east-west travel)</p> <p><input type="checkbox"/> I feel that sleep is a waste of time</p> <p><input type="checkbox"/> I enjoy sleeping very much</p> <p><input type="checkbox"/> I usually sleep with a bed partner</p> <p><input type="checkbox"/> I sleep with earplugs or eyeshades</p> <p><b><u>During the first 30 minutes after waking up in the morning, I usually feel:</u></b></p> <p><input type="checkbox"/> very groggy</p> <p><input type="checkbox"/> somewhat drowsy</p> <p><input type="checkbox"/> slightly drowsy, but awake</p> <p><input type="checkbox"/> alert</p>

<b><u>DAYTIME SLEEPINESS</u></b>	<b><u>DAYTIME SLEEPINESS (cont.)</u></b>	<b><u>DISTURBED SLEEP</u></b>
<p><input type="checkbox"/> I have sometimes fallen asleep at very inappropriate times, such as driving, eating or during a conversation.</p> <p><input type="checkbox"/> I have sometimes been so sleepy that I became confused or lost track of the topic of a conversation.</p> <p><input type="checkbox"/> I am frequently so sleepy during the day that my work is poor.</p> <p><input type="checkbox"/> I have had accidents or near accidents when driving because I felt so sleepy.</p> <p><input type="checkbox"/> I frequently do not feel sleepy at bedtime and stay up until it is so late that as a consequence, I get too little sleep.</p> <p><input type="checkbox"/> I would feel better if I slept at least one more hour every night.</p> <p><input type="checkbox"/> I feel that I sleep too much.</p> <p><input type="checkbox"/> I feel that I sleep too little.</p> <p><input type="checkbox"/> I function best in the morning.</p> <p><input type="checkbox"/> I've "come to" or suddenly become alert and found myself doing things without being aware of having started them or how I got there.</p> <p><input type="checkbox"/> I generally feel: <input type="checkbox"/> tired <input type="checkbox"/> sleepy all day.</p> <p><input type="checkbox"/> When I get a good night of sleep, I feel better the next day.</p> <p><input type="checkbox"/> Several times I recently got up later than planned, even though I went to bed at the right time.</p> <p><input type="checkbox"/> Usually I find myself falling asleep during half hour TV shows.</p> <p><input type="checkbox"/> Sometimes I perform a complex act such as driving a car to the wrong destination and not remembering how I did it.</p>	<p><input type="checkbox"/> I sometimes find myself doing things which make no sense (such as writing nonsense or mixing chocolate and gravy).</p> <p><input type="checkbox"/> I've had the sensation of a sudden weakness in my legs while awake (this may occur particularly in emotional situation, such as laughter, anger, etc.).</p> <p><input type="checkbox"/> I sometimes have felt paralyzed or unable to move when waking up or falling asleep.</p> <p><input type="checkbox"/> I have hallucinations or dreamlike images when I am not actually asleep, but while falling asleep or waking up.</p> <p><b><u>PARASOMNIA</u></b></p> <p><input type="checkbox"/> I have been told that I grind my teeth when I sleep.</p> <p><input type="checkbox"/> As an adolescent or adult, I have been seen sleepwalking.</p> <p><input type="checkbox"/> As an adolescent or adult, I have been heard sleep talking.</p> <p><input type="checkbox"/> My dreams are often very vivid.</p> <p><input type="checkbox"/> I feel that I dream too much.</p> <p><input type="checkbox"/> My dreams often awaken me.</p> <p><input type="checkbox"/> I often have frightening dreams.</p> <p><input type="checkbox"/> As an adult I have wet my bed.</p> <p><input type="checkbox"/> I've been told that I bang or twist my head at night.</p>	<p><input type="checkbox"/> I have been told that I snore very loudly.</p> <p><input type="checkbox"/> Sometimes a person cannot sleep in the same room with me because he or she is bothered by my snoring.</p> <p><input type="checkbox"/> My bed covers are very messed up in the morning.</p> <p><input type="checkbox"/> I am a very restless sleeper.</p> <p><input type="checkbox"/> I have been told that I kick or poke my bed partner while I am asleep.</p> <p><input type="checkbox"/> I sometimes awaken with a choking sensation.</p> <p><input type="checkbox"/> I've been told that I stop breathing when I sleep.</p> <p><input type="checkbox"/> I have fallen out of bed.</p> <p><input type="checkbox"/> I have been told that I make rolling or rocking movements in my sleep.</p> <p><input type="checkbox"/> I wake up suddenly from sleep with an unpleasant feeling of fear, anxiety, tension, or unhappiness.</p> <p><input type="checkbox"/> I have awakened from sleep once or more having vomited.</p> <p><input type="checkbox"/> When I wake during the night, I often have to get up and go to the bathroom.</p> <p><input type="checkbox"/> I sweat a lot when I sleep.</p> <p><input type="checkbox"/> I feel that the quality of my sleep is unsatisfactory,</p> <p><input type="checkbox"/> I have been told that my legs twitch or jerk while I am sleeping.</p> <p><input type="checkbox"/> I sometimes wake up with a headache.</p> <p><input type="checkbox"/> I sometimes have pain from my heart during the night.</p> <p><input type="checkbox"/> I usually have a bitter taste in my mouth when I awaken at night or in the morning.</p>

**INSOMNIA**

I have trouble falling asleep at night.

When I don't sleep well, I worry about it the next day.

When I wake up during the night, I have trouble going back to sleep.

I wake in the morning long before I have to.

Some nights, I never get to sleep no matter how hard I try.

When I try to go to sleep, my mind races with many thoughts.

At night when I go to bed, I don't feel sleepy.

I often sleep better in an unfamiliar bedroom, such as a hotel room.

When I try to fall asleep, I become anxious or nervous.

When I try to fall asleep, I worry about whether or not I can sleep.

When I try to fall asleep, I often feel hungry or thirsty.

When I try to fall asleep, I feel pain.

Pain often wakes me up or keeps me from going back to sleep.

I often take sleeping pills in order to sleep.

I have a creeping, crawling sensation in my legs when I lie down to sleep.

When I do sleep, I feel that I sleep very well.

**INSOMNIA (cont.)**

I am a very light sleeper; I am easily awakened by noises.

My sleep is disturbed because of my bed partner.

Heat or cold disturbs my sleep.

Generally I get up in the middle of the night for a snack.

**MEDICAL CONDITIONS**

I have been told that I shake my head at night.

I have been told that I have convulsions, fits, or seizures at night.

I have had convulsions, fits, or seizures during the day.

I have bitten my tongue while asleep.

I sometimes wake up with heartburn.

I sometimes wake up with lower back pain.

I sometimes wake up with feelings of aching or "pins and needles" in my legs.

I am unable to sleep in a flat position because of shortness of breath.

I sometimes cough up sputum or mucus during the night or in the morning.

I have gained more than 10 lbs. in the last year.

I have lost more than 10 lbs. in the last year.

I have been told that I have high blood pressure.

I rarely drink alcoholic beverages.

**MEDICAL CONDITIONS (cont.)**

I consume the following:

**Weekdays                      Weekend days**

Bottles (cans of beer)

\_\_\_\_\_

Glasses of wine

\_\_\_\_\_

Shots of liquor

\_\_\_\_\_

I use alcohol in order to get to sleep:

sometimes  often

**MEN**

I awaken with painful penile erections.

I have problems obtaining or maintaining penile erections.

**WOMEN**

My sleep problem varies according to the stage of my menstrual cycle.

I am currently taking birth control pills.

My sleep problem started or got worse at menopause.

**SLEEP HISTORY**

**Place a check beside any of the following statements that are true for you (if possible, please ask your parents or older brothers or sisters to help you remember your childhood behavior).**

- I sometimes wet the bed after age six.
- As a child I talked in my sleep.
- As a child I sleepwalked.
- As a child I had frequent nightmares.
- As a child I screamed in my sleep.
- As a child I had convulsions during sleep.
- As a child I banged or rocked my head on the bed to sleep.
- My current sleep problem started in childhood.
- I used to fall asleep in school as a child and/or adolescent.
- I always had to fight the urge to sleep during my classes at school when I was a child and/or adolescent.
- As a child, I used to stay up late in the evening.
- I was told that I snored while sleeping as a child or teenager.
- I was considered a hyperactive or hyperkinetic child or teenager.

**HISTORY**

**Questions that apply to your extended family: parents, children, aunts, uncles, cousins, nephews, nieces, etc.-relatives related by "blood".**

- A relative died of "crib death" or sudden infant death.
- Others members of my family have insomnia.
- Other members of my family snore loudly at night.
- Other members of my family frequently fall asleep during the day or evening.
- Other members of my family are troubled by sudden attacks of physical weakness or paralysis, particularly in emotional situations.
- Other members of my family have been hyperactive or hyperkinetic as children.
- Other members of my family have the same sleep problem that I do.

## EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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. Use the following scale to choose the most appropriate number for each situation and circle the appropriate number in the box below 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			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
As passenger in car for an hour without a break	0	1	2	3
Lying down in the afternoon when circumstances permit	0	1	2	3
Sitting and 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 Score: \_\_\_\_\_

**St. Joseph Hospital Sleep Disorders Center**  
**700 Broadway**  
**Fort Wayne, IN 46802**  
**Office 260-425-3552 Fax 260-425-3553**

**HOME MEDICATION LIST**

Please complete this form with any and all prescription and non-prescription medications, herbals and vitamins you are currently taking and bring them with you to the Sleep Center in their original containers if possible.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
D.O.B. \_\_\_\_\_  
Height: \_\_\_\_\_  
Weight: \_\_\_\_\_

Allergies and Reactions: Including Drugs/Dye, Latex, Nuts, Bananas, Soy Products, Eggs. Iodine, Chemical, Contrast Media, Food:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please indicate here if patient takes no home medications.**

<u>Medication Name</u>	<u>Dose</u>	<u>Frequency</u>	<u>Reason for Med.</u>	<u>Last Taken</u>
Example: Tylenol	500 mg	2 every 4 hours	Shoulder Pain	4pm
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Initial List obtained by:

- Medication listed verbally by patient or family
- Patient completed list
- List written by patient or family
- Medication bottles brought in for study
- Patient unable to supply medication list information

**I have reviewed this list with the patient.**

\_\_\_\_\_  
**Technician Signature**