TOWER SLEEP
MEDICINE

Sleep and Medical History

Name: _____ Age: _____Date: _____

Cell Phone Number:_____ Email Address:_____

Height _____ Weight _____ Neck Size _____ Dress Size _____

Primary Care Physician _____ Referring Physician_____

Have you ever had a sleep study before? _____ If yes, do you know what the diagnosis or conclusion was? _____

Have you ever used CPAP or BiPAP before? _____ Are you currently using CPAP or BiPAP? _____ If yes, do you know what the pressure setting is? _____ .

Please describe your sleep concern:

_____

_____

_____

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Tower Sleep Medicine

Name:_____ DOB:_____ Date:_____

Epworth Sleepiness Scale

0 Would **never** doze

1 **Slight** chance of dozing

2 **Moderate** chance of dozing

3 **High** chance of dozing

	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theatre or a 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 when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in the traffic	0	1	2	3
Total Score:				

Functional Outcome of Sleep Questionnaire-10 (FOSQ-10)

1 Yes, **extreme**

2 Yes, **moderate**

3 Yes, a **little**

4 **No**

Do you have difficulty concentrating on the things you do because you are sleepy or tired?	1	2	3	4
Do you generally have difficulty remembering things because you are sleepy or tired?	1	2	3	4
Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy?	1	2	3	4
Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy?	1	2	3	4
Do you have difficulty visiting your family or friends in their home because you become sleepy or tired?	1	2	3	4
Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?	1	2	3	4
Do you have difficulty watching a movie or video because you become sleepy or tired?	1	2	3	4
Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?	1	2	3	4
Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?	1	2	3	4
Has your mood been affected because you are sleepy or tired?	1	2	3	4
Total Score:				

Medical History

1. Please indicate for which of the following **medical** conditions you are currently (*or have ever*) receiving treatment:

- Heart disease (heart attack, murmurs, arrhythmia, congestive heart failure, other) [Yes *please circle and dates* / No] _____
- High blood pressure [Yes / No]
- Diabetes mellitus [Yes / No]
- Elevated cholesterol [Yes / No]
- Seizure or other neurologic condition [Yes / No]
- Stroke [Yes / No]
- History of head trauma [Yes / No]
- Asthma [Yes / No] Age when diagnosed _____
- Emphysema/COPD [Yes / No] Age when diagnosed _____
- Depression [Yes / No]

2. Use the space below to list additional items from your medical history:

_____

_____

_____

_____

_____

_____

_____

_____

3. List all your previous surgeries or operations. Make sure you list any prior surgeries or procedures for snoring or sleep apnea. (□ None):

Operation	Year

4. What medicines are you presently taking (□ None)?

Medication	Dose	Frequency

5. List **allergies** or **reactions** to any medications (□ None):

Medication	Reaction

6. Please provide us with your family's sleep medical history. Are you aware of any close relatives with sleeping problems?

7. What is your occupation? Do you do shift/night work?

8. What is your marital status? Do you have any children?

9. How much alcohol do you drink per week? Have you every drunk significantly more than this? Have you ever been treated for alcoholism?

10. Have you used any recreational drugs (including marijuana)? Which and when?

11. Please use the space below to add any additional information from your sleep medical history that you feel is pertinent:

_____ _____

Patient (or Parent/Legal Guardian Signature) Date