St. Tammany PARISH HOSPITAL
WORLD-CLASS HEALTHCARE. CLOSE TO HOME.

Sleep Medicine Initial Evaluation Form

Last Name: _____ First Name:_____
Date of Birth: _____ Gender: M__F__ Language: English __Other_____
Race: black___ white___ Hispanic___ other___ Height_____ Weight_____
Address: _____
City: _____State: _____Zip Code: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail:_____
Referring Physician: _____
Medical Equipment Supplier: **___None/no preference**
___Northlake Medical Supply
___Health Management
___ Quality ___ Apria ___Egan
Other: _____

Pharmacy that I Use: _____

History of Present Illness

I have a problem with
___ Snoring
___ Witnessed apnea (stop breathing)
___ Difficulty falling asleep
___ Difficulty staying asleep
___ Early morning awakening
___ Difficulty arising in the morning
___ Unrefreshing sleep
___ Daytime sleepiness
___ Unusual behavior during sleep
___ Pain disrupting sleep
___ Nocturnal leg cramps
___ Sleep walking
___ Nightmares
___ Sleep talking
___ Sleep eating
___ Cough disturbs sleep
___ Shortness of breath disturbs sleep

Other_____
_____

This problem began _____days/weeks/months/years ago
____ It is going away or gone
____ It just started
____ It has been getting worse
____ It is a long-term problem

Severity: Mild ___Moderate ____Severe___
It has effected: Daily Activities ____Driving ____Work___

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NAME:_____**DOB:**_____

For snoring/sleep apnea patients-I have problems with

____ Loud snoring
____ Awaken gasping
____ I have been told I stop breathing
____ I am a mouth breather
____ I have to sleep upright at night
____ Enlarged tonsils or adenoids
____ Sinus congestion
____ Dry mouth
____ Chest congestion
____ Sore throat

Previous Sleep Studies -Date and location _____

For pain patients-I have problems with

____ Headache
____ Heartburn
____ Lower back
____ Middle back
Other_____
____ Upper back/neck
____ Chest
____ Abdomen
____ Joint

Restless Leg Syndrome

____ I jerk in my sleep
____ My legs are restless
____ Leg discomfort is relieved by movement
____ My leg problem is worse at bedtime or if I am immobilized

Narcolepsy

____ I have weakness or paralysis with strong emotions
____ I have had paralysis at sleep onset or on awakening
____ I have had hallucinations at sleep onset or on awakening

Sleep Medicines

____ None
____ I am currently using_____
____ It is helping my sleep
____ It is giving me problems

I have also used_____
_____
_____

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NAME:_____**DOB:**_____

Review of Systems

Constitutional
___ Fever
___ Night sweats
___Weight gain ___ lbs.
___Weight loss ___ lbs.
Metabolic
___ Fatigue
___ Hair loss
Psychiatric
___ Depression
___ Anxiety
Neurologic
___ Numbness
___ Seizure
___ Dizziness

Eyes
___ Dry eyes
___ Eye irritation
___ Vision change
Nose
___ Nosebleeds
___ Pain itching in nose
___Worsening nasal stuffiness
___ Sore on nasal bridge
Cardiovascular
___ Chest pain
___ Shortness of breath walking
___ Palpitations

Gastrointestinal
___ Abdominal pain
___ Vomiting
___ Diarrhea
Genitourinary
___ Increased urinary frequency
___ Decreased urinary frequency
___ Difficulty urinating
Skin
___ Itching
___ Rash
Musculoskeletal
___ Muscle aches
___ Joint pain
___ Swelling legs

Past Medical History

___ Anxiety
___ Atrial fibrillation
___ Arthritis
___ Asthma
___ Congestive heart failure
___ COPD
___ Coronary artery disease (heart disease)
___ Depression
___ Diabetes
___ Gastroesophageal reflux
___ Hypertension
___ Kidney disease
___ Liver disease
___ Low testosterone
___ Seizure disorder
___ Sinus disease
___ Thyroid disease
___ TIA/stroke

Past Surgical History

___ Back surgery
___ Carpal tunnel surgery
___ Cataract surgery
___ Coronary artery (CABG)
___ Gall bladder
___ Hernia repair
___ Hip surgery
___ Hysterectomy
___ Knee surgery
___ Neck surgery
___ Sinus surgery
___ Sleep apnea/snoring surgery
___ Thyroid surgery
___ Tonsillectomy

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NAME: _____DOB:_____

Social History

Alcohol use
Never ___occasional ___moderate ___heavy___
Daily Caffeine use in 8 oz. cups
Coffees ____colas _____teas___
Marital status
Single ___married ___divorced ___widowed___
Smoking
Never ___former ___current___
Years smoker_____
Packs per day_____
Bed habits
Usual bedtime _____Usual time out of bed_____
Usual number of hours sleep_____
Nap yes ___no___ Duration nap_____
Currently employed: yes ___no___ Occupation_____
Shift work yes ___no___

Medication Allergies:

_____

Medications

Please list all medications prescription including over the counter/herbal that you are using at the present time:

Medication	**Dose**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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NAME: _____DOB:_____

Family Health History- list medical problems
Mother _____
Father _____
Siblings _____

Epworth Sleepiness Scale

Use the following 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

chance of dozing(0-3)

Sitting and reading----------[ ]
Watching TV----------[ ]
Sitting inactive in a public place (e.g. theatre or a meeting)----------[ ]
As a passenger in a car for an hour without a break----------[ ]
Lying down to rest in the afternoon when circumstances permit----------[ ]
Sitting and talking to someone----------[ ]
Sitting quietly after a lunch without alcohol----------[ ]
In a car while stopped for a few minutes in traffic----------[ ]

Total Score:_____