MEADOWS
SLEEP CENTER
A division of Meadows Healthcare Alliance, Inc.

PATIENT DEMOGRAPHICS

Name :_____ Age:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip Code: _____ SSN:_____

Home Phone Number: (___) _____ Cell Number: (___) _____

Email Address:_____

Height:_____ Weight:_____ Sex:_____ Marital Status:_____

Occupation: _____ Years in Job:_____

Employer: _____

Employer's Address:_____

City:_____ State:_____ Zip Code: _____

Next of Kin:_____

Relationship:_____ Phone Number: (___) _____

Emergency Contact:_____

Relationship:_____ Phone Number: (___) _____

How did you hear about us?

☐Physician ☐Television ☐Newspaper ☐Friend ☐Other:_____

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EPWORTH SLEEPINESS SCALE

Name :_____ Date:_____

Your Age (yrs):_____ Your Sex (M = Male, F = Female):_____

How likely are you to doze off or fall asleep in the following situations in contrast to feeling just tired? This refers to your usual way of life in recent times.

Even if you haven't 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:

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

mlc 2004

Reference: Johns,M.W. A new method for measuring daytime sleepiness: the Epworth Sleepiness Scale. SLEEP. 1991; 14:540-5.

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MEDICATION SUMMARY

Please list ALL current medications that you are taking that are prescription, over-the-counter, or for recreational use.

Please list the name of the medication, dosage, and times per day the medication is used.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list any allergies you have that you are aware of.

1. _____
2. _____
3. _____
4. _____
5. _____

*All information provided is held confidential and will not be discussed with any person that is not involved with your care *

Pre-Sleep Questionnaire

Name :_____ Date:_____

Sex: _____ Race: _____ Height: _____ Weight: _____ Age: _____ DOB: _____

Are you a smoker? _____ If yes, how many years? _____ How many ppd? _____

Sleep History: Please place an "X" in the box next to each statement that applies to you.

1. _____ I have been told I snore.
2. _____ I have been told I stop breathing when I sleep.
3. _____ I feel sleepy during the day even though I slept through the night.
4. _____ I have a history of fall risk.
5. _____ I sweat excessively during the night.
6. _____ I frequently awaken with headaches.
7. _____ I am overweight or have gained weight.
8. _____ I have difficulty falling asleep.
9. _____ I wake up during the night and cannot go back to sleep.
10. _____ I experience muscle tension in my legs even when I am otherwise relaxed.
11. _____ I am aware that parts of my body jerk and disturb my sleep.
12. _____ I have been told that I kick at night.
13. _____ Sometimes, I cannot keep my legs still at night and I just have to move them.
14. _____ I experience leg pain during the night.
15. _____ I have frequent sore throats
16. _____ I am hoarse in the morning
17. _____ I wake up at night coughing and wheezing
18. _____ During the night I suddenly wake up gasping and my heart pounding
19. _____ Have you been diagnosed with symptomatic chronic heart failure?
    If yes, who is your cardiologist? _____

Medical History: Please place an "X" in the box by any problem or illness you have/had.

_____ Heart Disease	_____ Allergies	_____ Heartburn
_____ Hernia	_____ Seizures*	_____ Bladder Trouble
_____ Ringing of the ears	_____ Impotence	_____ Kidney Trouble
_____ Headaches	_____ Eye Trouble	_____ Dizziness*
_____ Epilepsy*	_____ Gout	_____ Asthma
_____ Black outs*	_____ Hearing Trouble	_____ Bronchitis
_____Hemophilia	_____ Pneumonia	_____ Fainting*
_____ Ulcers	_____ Meningitis	_____ Cancer
_____ Prostate Trouble	_____ Diabetes	_____ High Blood Pressure
_____ Mental Problems	_____ Depression	_____ Back Trouble
_____Tuberculosis	_____ Low Blood Pressure	_____ Sleep Disorders*
_____ COPD	_____Muscle Cramps	

*Past sleep studies or surgery related to sleep disorders.
**Please indicate what time you need to get up if it is before 5:30 a.m.

Patient's Signature: _____ Technician: _____