The Corvallis Clinic
PHYSICIANS & SURGEONS

Sleep Medicine
3680 NW Samaritan Drive
Corvallis, OR 97330
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Sleep Medicine New Patient H & P

Last Name:..... First Name:.....

Date of Birth:..... Primary Physician:..... Visit Date:.....

What is the reason for your visit? .....

.....

How long have you had this problem?.....

Sleep History

Check if you have had or if anyone has noticed you having these symptoms

❑ Snore	❑ Stop breathing while sleeping	❑ Wake up gasping for air
❑ Restless sleep	❑ Have morning headaches	❑ Act out your dreams
❑ Talk in sleep	❑ Take medicine for sleep	❑ Have vivid dreams/nightmares
❑ Walk in sleep	❑ Have leg jerks	❑ Have nighttime wheezing
❑ Creeping/crawling in leg	❑ Feel the need to move your legs	❑ Awaken with a dry mouth
❑ Grind your teeth	❑ Pain that interferes with sleep	❑ Thoughts that disrupt sleep

What is your typical sleep schedule on work days?
Bedtime:..... Rise time:..... How long to fall asleep: .....
What is your typical sleep schedule on days off?
Bedtime:..... Rise time:..... How long to fall asleep:.....
Is your nighttime sleep refreshing?.....
Do you sleep on your: ❑ Back ❑ Side ❑ Stomach ❑ Both
If you snore, do you snore on your: ❑ Back ❑ Side ❑ Stomach ❑ Both
Do others leave the room due to your snoring? ❑ Yes ❑ No
How many times do you wake up during the night? ..... For restroom visits? .....
How long does it take to fall back asleep?.....
If you have difficulty falling asleep, what do you do?.....
In bed, do you: ❑ Read ❑ Eat ❑ Do work activities ❑ Watch TV
Are you sleepy during the day? ❑ Yes ❑ No If so, what time of day is worst?.....
Are you fatigued during the day? ❑ Yes ❑ No If so, what time of day is worst?.....
Do you take naps? ❑ Yes ❑ No How many times per week?.....
Are they refreshing? ❑ Yes ❑ No How long do the naps that are refreshing last?.....
Have you ever felt weak in your muscles when either telling or hearing a joke? ❑ Yes ❑ No
While waking up or falling asleep have you ever:
Felt like you cannot move (feel paralyzed)? ❑ Yes ❑ No
Heard or seen things that are not there (as if dreaming, but awake)? ❑ Yes ❑ No

Family History

Do you know any blood relatives who have or had the following? Please circle and give relationship

Seizures ..... Insomnia ..... Excessive sleepiness .....

Dementia ..... Sleep Apnea ..... Narcolepsy .....

Restless Legs Syndrome.....

Is there someone in the family with a similar illness to yours? ❑ Yes ❑ No If so, who?.....

Social History

Marital status..... How long?.....
Education highest level and degree(s).....
Occupation/past occupation..... How long?.....
Do you work shift work? ❑ Yes ❑ No If so, what shifts?.....
Do you have a: Commercial driver license? ❑ Yes ❑ No Pilot license? ❑ Yes ❑ No
Do you operate dangerous machinery? ❑ Yes ❑ No Work with nuclear or chemical agents? ❑ Yes ❑ No

(over)

Past Surgical History Past surgeries/hospitalizations

Have you had your tonsils removed? ❑ Yes ❑ No If so, at what age?

Habits (Y = Yes, N = No) please circle

Do you exercise? Y or N If so, what time of day?
Cigarette smoking? Y or N When did you start, and how much currently?
Smokeless tobacco? Y or N When did you start, and how much currently?
Do you drink alcohol? Y or N If so, how many drinks per week?
Do you drink coffee, caffeinated sodas or tea? Y or N If so, how many cups per day?

Past Medical History Check box if you have a history of:

❑ Anxiety	❑ Diabetes	❑ Kidney Disease
❑ Arthritis/Rheumatologic condition	❑ Drug or alcohol addiction	❑ Lung Disease
❑ Cancer	❑ Fibromyalgia	❑ Seizures or other Neurological disease
❑ Chronic Pain	❑ Heart Disease	
❑ Depression	❑ High Blood Pressure	❑ Stroke or TIA
❑ Deviated Nasal Septum	❑ High Cholesterol	❑ Thyroid Problems

Other

Allergies Do you have any allergies to medicines, tape or adhesives? ❑ Yes ❑ No
If so, which ones?

Medications Please list all medications, including over-the-counter meds and herbal remedies

Review of Systems

General:	**ENT:**	**Cardiovascular:**
❑ Night sweats	❑ Sinus congestion	❑ Chest discomfort
❑ Weight gain	**Respiratory:**	❑ Rapid heart beats
❑ Weight loss	❑ Trouble breathing	❑ Leg or feet swelling
Neurologic:	❑ Coughing or wheezing	**Endocrine:**
❑ Passing out	**Musculoskeletal:**	❑ Heat intolerance
❑ Headache	❑ Back pain	❑ Cold intolerance
❑ Memory problems	❑ Muscle aches or cramps	❑ Positive pregnancy test
Psychiatric:	**Genitourinary:**	**Gastrointestinal:**
❑ Depression	❑ Frequent urination	❑ Nausea
❑ Anxiety	❑ Erectile dysfunction	❑ Heartburn

Epworth Sleepiness Scale

Please estimate your risk of dozing or falling asleep in the following situations, using the scale below.

0 = no chance
1 = slight chance
2 = moderate chance
3 = high chance

Situation	Chance of dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. theater/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	