

*PLEASE COMPLETE THE FOLLOWING INFORMATION AND BRING IT TO YOUR APPOINTMENT*

Name: \_\_\_\_\_  
Soc. Sec. #: \_\_\_\_\_

Referring Doctor Name: \_\_\_\_\_  
Referring Doctor Phone: \_\_\_\_\_

What sleep related problems are you having that led you to this test?

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

List all of your medical illnesses:

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

List your current medications (or bring a complete list if there is insufficient space provided here):

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

1. Have you ever used medications to help you sleep? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, when did you last use any sleeping medication, what kind was it, for how long, and in what dose? \_\_\_\_\_

2. Normal Bedtime(s): \_\_\_\_\_ Normal Risetime(s): \_\_\_\_\_

3. How many hours per week do you work? \_\_\_\_\_ Does your work involve rotating shifts? Yes \_\_\_ No \_\_\_

4. Do you travel frequently across time zones? Yes \_\_\_\_\_ No \_\_\_\_\_

5. Do you have difficulty falling asleep? Yes \_\_\_ No \_\_\_ How long does it take you to fall asleep? \_\_\_\_\_

6. Do you awaken during the night? Yes \_\_\_ No \_\_\_ If YES, how many times and for how long? \_\_\_\_\_

7. What awakens you and how long does it take to fall back to sleep? \_\_\_\_\_

8. Do you feel refreshed upon waking? Yes \_\_\_\_\_ No \_\_\_\_\_

9. Do you feel excessively sleepy during the day? Yes \_\_\_\_\_ No \_\_\_\_\_

10. Do you have sleepiness during the day that you can't resist (e.g. falling asleep while driving, eating, at work)?  
Yes \_\_\_ No \_\_\_

11. Do you or have you ever lost muscle tone in part or all of your body when suddenly surprised, angered, frightened, or amused (e.g. when laughing hard at funny jokes). Examples of muscle tone loss would be knees buckling, jaw going slack, falling, etc., without any loss of consciousness or change of consciousness. Yes \_\_\_\_\_ No \_\_\_\_\_

12. In the evenings or at bedtime when trying to fall asleep, do you have restless legs, leg discomfort when trying to keep legs still, or need to move your legs frequently to get comfortable? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, does movement of your legs provide short-term (seconds to a minute) relief from leg discomfort before you have to move them again to get comfortable? Yes \_\_\_\_\_ No \_\_\_\_\_

13. When falling asleep or awakening, do you ever feel paralyzed or unable to move at all? Yes \_\_\_ No \_\_\_

14. When attempting to fall asleep, do you ever have vivid dream-like episodes (hallucinations) Yes \_\_\_\_\_ No \_\_\_\_\_

15. Do you walk in your sleep? Yes \_\_\_ No \_\_\_ If YES, do you ever exhibit complex behaviors when sleep walking – like wandering out of the room or house, eating, performing tasks or automatic behaviors you don't remember doing the next morning? Explain: \_\_\_\_\_  
\_\_\_\_\_
16. Do you ever awaken from sleep screaming, violent and confused, or hit, slap, kick things or bed partners while asleep? Yes \_\_\_ No \_\_\_ If YES, explain: \_\_\_\_\_  
\_\_\_\_\_

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Has a bed partner or other family member witnessed you demonstrate these behaviors? Yes \_\_\_ No \_\_\_

17. Has a bed partner or other family member ever see you act out a dream or show violent behavior while asleep, which you don't remember? Yes \_\_\_\_\_ No \_\_\_\_\_
18. Do you grind your teeth while you sleep? Yes \_\_\_\_\_ No \_\_\_\_\_
19. Have you ever wet your bed as an adult? Yes \_\_\_\_\_ No \_\_\_\_\_
20. Do you snore? Yes \_\_\_ No \_\_\_ In which sleeping positions and how loudly? \_\_\_\_\_  
\_\_\_\_\_
21. Do you ever stop breathing while you sleep? Yes \_\_\_\_\_ No \_\_\_\_\_ Not Sure \_\_\_\_\_  
If YES, in which sleeping positions and for how long? \_\_\_\_\_
22. Do you ever awaken during the night gasping for breath, or with a snore you hear yourself? Yes \_\_\_ No \_\_\_
23. Do you drink alcohol? Yes \_\_\_ No \_\_\_ What/how much/how often/time of day: \_\_\_\_\_
24. Do you use caffeine? Yes \_\_\_ No \_\_\_ What/how much/how often/time of day: \_\_\_\_\_
25. Do you smoke? Yes \_\_\_ No \_\_\_ How much and for how long? \_\_\_\_\_
26. Has anyone in your family been diagnosed with narcolepsy? Yes \_\_\_ No \_\_\_ If YES, who and what relation are they to you? \_\_\_\_\_
27. Do you have any family members with sleep apnea (Yes \_\_\_ No \_\_\_) or severe snoring? Yes \_\_\_ No \_\_\_ Are they overweight? Yes \_\_\_ No \_\_\_ Please Explain: \_\_\_\_\_  
\_\_\_\_\_
28. What are your CURRENT neck size, height and weight? Neck size: \_\_\_ Height: \_\_\_ Weight: \_\_\_
29. Have your neck size and weight changed in the last year? Yes \_\_\_ No \_\_\_ In the past 10 years? Yes \_\_\_ No \_\_\_
- 30. Please add on a separate sheet anything else that you feel may help the clinicians better understand your sleep.**