BAY AREA SLEEP EVALUATION CENTER

Patient Sleep Interview

NAME: Last_____ First:_____ MI:_____
Address:_____ C/S/Z:_____
Phone: Home:_____ Work:_____ Cell:_____
Email address:_____
DOB: _____ Age:_____ Gender: M / F Marital Status: _____
SSN: _____ Occupation: _____
Height: _____ Weight: _____ Referred By: _____

Sleep Complaint:

What is your main sleep complaint? _____
_____
_____
_____
_____
How long has this been a problem? _____
(Please mark all that apply and please explain.)
____I have had problems with memory. _____
____I have had problems with concentration. _____
____I have noticed changes in my mood. _____
____I am having sexual problems. _____
____I have been depressed lately. _____
____I often travel across times zones or work rotating shifts. _____

Sleep Habits:

What time do you usually go to bed on weekdays?_____ Weekends? _____
How long does it usually take you to fall asleep? _____
What time do you usually get up on weekdays? _____ Weekends? _____
How many times do you usually awaken at night? _____ For how long? _____ Why? _____
How many hours of sleep do you usually get in a typical night? _____
How do you usually feel in the morning? Very Sleepy / Quite Sleepy / Wide Awake
Do you nap during the day? _____ How often? _____ How long? _____

How likely are you to doze off or fall asleep in the following situations?

0- Never 1- Slight Chance 2- Moderate Chance 3- High Chance

_____Sitting and Reading
_____Watching TV
_____ Lying down in the afternoon
_____ Sitting quietly after lunch (no alcohol)
_____Sitting inactive in a public place (Ex. Theatre)
_____ A passenger in a car for an hour or more
_____ Stopped in traffic during driving
_____ Sitting and talking to someone

TOTAL SCORE (add the scores up) _____ **ESS**

During sleep, I have noticed or have been told that I: (*please mark all that apply*.)

____ Snore lightly	____ Grind my teeth	____ Make choking sounds
____ Sleep talk	____ Cry in my sleep	____Bite my tongue
____ Twitch or kick my legs	____ Sleep Walk	____ Other
____ Become rigid or shake	____ Wet the bed	____Other
____ Stop breathing	____ Have occasional loud snorts	
____ Snore loudly		

Medical History:

I have been told that I have: (*please circle any of the following that apply*)

High blood pressure	Elevated Cholesterol	Migraine or frequent headaches
Sinus problems	Stroke	Parkinson's
Diabetes	GI disease	Dementia (Alzheimer's)
Arthritis	Cancer	Sleep Apnea
Thyroid Problems	Restless legs	Frequent nighttime urination
Anemia	Depression	Obesity
Heart disease	Liver Disease	Lung disease
Seizures	Congestive Heart Failure	Other: _____

Past medical or surgical history: (*include all hospitalizations*)

Date:	Problem:	Treatment/Surgery:	Date:	Problem:	Treatment/Surgery:
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		

Have you ever had a sleep study done?_____ When? _____ Where? _____
Have you ever used a CPAP or BiPAP? _____ When?_____ What pressure? _____
Do you use oxygen at home? _____ How often? _____ How much? _____
Do you smoke? _____ How much? _____ per day. How long? _____years.
Do you drink alcohol? _____ How much? _____ How often? _____
Do you drink caffeinated drinks? _____ How many? _____ per day.

Medication List (*include over the counter medications*)

Drug:	Dosage:	Reason:	Drug:	Dosage:	Reason:
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		