Coastal Carolina Health Care, PA
physicians working together for your good health

**CCHC Sleep Lab**
**1020 Medical Park Ave**
**New Bern, NC 28562**

**Phone 252.634.2240**
**Fax 252.634.2241**

# PATIENT HISTORY FORM

Name: _____ Date: _____

Sex: ☐ Male ☐ Female Race: _____ Age: _____

Height: _____ ft. _____in. Current Weight: _____ DOB: _____

Current Occupation: _____

Home Address: _____

_____

Home Telephone Number: ( ) _____-_____ Work Number: ( ) _____-_____

1. Do you have any problems with your sleep? _____
2. Have you had a sleeping problem diagnosed in the past? Yes No
   If yes to # 2, what was the problem? _____
   If yes to #2, what treatment(s) was/were needed? _____
   Did the treatment(s) help? Yes No
3. Where was the diagnosis made? _____

## Sleep Schedule and Sleep Hygiene

4. Do you keep a fairly regular sleep/wake schedule? Yes No
5. What time do you usually go to bed on week days or days that you work? __ __:__ __a.m./p.m. (circle
6. What time do you usually get up on week days or days that you work? __ __:__ __a.m./p.m. (circle)
7. What time do you usually go to bed on weekends or days that you don't work? __ __:__ __a.m./p.m.(c
8. What time do you usually get up weekends or days you don't work? __ __:__ __a.m./p.m.
9. Do you usually feel well-rested upon awakening? Yes No
   If you answered no to #9 above how do you feel? _____

_____

10. How many hours do you usually sleep?
    Week days or days that you work _____hours
    Weekends or days that you don't work _____hours
11. Do you nap during the day? Yes No
    If yes to #11: Number of Naps Average Length
    Weekdays (work days) _____ _____
    Weekends ( days not working) _____ _____
12. Do you read in bed? Yes No
13. Do you watch TV in bed? Yes No
14. Do you look at your bedroom clock at night? Yes No

15. Do you have arguments in bed? Yes No
16. Do you eat in bed? Yes No
17. Do you worry in bed? Yes No
18. Do you currently do shift work? Yes No
19. Have you done shift work in the past? Yes No
    If yes to #18 or #19, do you have trouble sleeping when you are doing shift work? Yes No
20. Does your spouse perform shift work? Yes No
    If yes to #18-#19 above, please Explain:_____
_____

**Insomnia**

Answer the following questions assuming "night" means your major sleeping time.

21. Do you often have trouble getting to sleep at night? Yes No
22. What is the average number of minutes it takes you to fall asleep at night? _____minutes
23. Do you often have awakenings during the night? Yes No
    If yes to #23, what is the average number of times per night you wake up? _____times per night
    If yes to # 23, why do you awaken? _____
24. Do you have long periods when you awaken and are not able to get back to sleep? Yes No
    If you answered yes to #24, how long are these periods of Wakefulness when added together? _____minutes per night
25. Are you bothered by waking up too early and not being able to go back to sleep? Yes No
    If yes to # 25, what is the number of nights per week? _____

**Movement**

26. Do you awaken yourself by kicking your legs, or other sudden movements during the night? Yes No
27. Has your bed partner ever complained of your legs kicking or other sudden movements during the night? Yes No
28. Do you have a restless sense of discomfort (crawling sensation) in your legs during waking hours? Yes No

**Parasomnias**

29. Did you have a sleep problem as a child? Yes No
    If yes to #29, describe: _____
_____

30. Do you currently have nightmares or night terrors? Yes No
    If yes to #30, how frequently?_____ times per week/month/year (circle one)
    If yes to #30, at what age did they begin? _____Years
31. Do you grind or clench you teeth at night? Yes No
32. Did you frequently wet the bed as a child? Yes No
33. Have you ever wet the bed as an adult? Yes No
34. Have you ever been told that you walk in your sleep? Yes No
35. Have you recently walked in your sleep? Yes No
36. Have you ever been told you make unusual movements such as talking, swinging arms about, acting out dreams, etc. during sleep? Yes No

**Excessive Sleepiness**

37. Do you feel excessively sleepy in the daytime? Yes No
    If yes to #37 how long? _____months/years (circle)
38. Do you feel your sleepiness is a result of poor quality of nighttime sleep? Yes No
39. How likely are you to doze off or fall asleep in the following situations, in contrast to just being tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the mos appropriate number for each situation:
    0= would ***never*** doze
    1= ***slight*** chance of dozing
    2= ***moderate*** chance of dozing
    3= ***high*** chance of dozing

| | |
|---|---|
| Sitting and reading | _____ |
| Watching TV | _____ |
| Sitting, inactive in a public place | _____ |
| 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 with someone | _____ |
| Sitting quietly after lunch without alcohol | _____ |
| In a car, while stopped for a few minutes in traffic | _____ |

40. Have you ever felt sudden weakness when you laughed or got angry? Yes No
    If yes to #40, describe_____
41. Have you ever been unable to move your body just as you were falling asleep or waking up? Yes No
    If yes to #41, describe_____
42. Have you ever had exceptionally vivid dreams just as you were falling asleep or waking up? Yes No
    If yes to #42, describe_____
43. Have you ever had a driving accident or a near miss accident because you were sleepy? Yes No
    If yes to #43, describe_____

**Respiration**

44. Have people who have shared (or are sharing) your bedroom told you that you snore?
Never_____ rarely (1-2x per yr) _____ occasionally (4-8x per yr) _____ sometimes (1-2x per mo) ____

Often (1-2x per wk) _____ usually (3-5x per wk) _____ Always (every night) _____ I don't know_____

Duration (#44) _____months/years (circle)
Can your snoring be heard through closed doors? Yes No

45. Have you been told by other people that you gasp, choke, or snort while you are sleeping?
Never_____ rarely (1-2x per yr) _____ occasionally (4-8x per yr) _____ sometimes (1-2x per mo) ___
Often (1-2x per wk) _____ usually (3-5x per wk) _____ Always (every night) _____ I don't know____

46. Have you been told that you stop breathing during sleep? Yes No
If yes to # 46, how often do you stop breathing during your sleep?
Never_____ monthly_____ weekly_____ daily_____

47. Do you wake up with morning headaches?
Never_____ monthly_____ weekly_____ daily_____

48. Do you awaken with a dry mouth or sore throat?
Never_____ monthly_____ weekly_____ daily_____

49. Do you wake with a choking or gasping sensation?
Never_____ monthly_____ weekly_____ daily_____

50. Does sleep position affect your snoring? Yes No
If yes to #50, in which sleep position do you snore most loudly?
Back____ on right side_____ on left side_____ stomach____ other (please describe) _____

51. Do you have difficulty breathing through your nose? Yes No

52. Have you ever had surgery on you upper airway? Yes No
(Tonsillectomy or sinus operation, etc)?
If yes to # 52, please describe_____

Please recall your weight history: N/A if not applicable

53. Weight at age 20 _____lbs
54. Weight at age 30 _____lbs
55. Weight at age 40 _____lbs
56. Weight at age 50 _____lbs
57. Weight at age 60 _____lbs
58. Heaviest weight _____lbs Age at heaviest weight _____years
59. Have you attempted to diet? Yes No

**Family History**

60. Do members of your immediate family (e.g., father, mother
Brother, sister, children) snore? Yes No

61. Do members of your immediate family have excessive
Daytime sleepiness? Yes No
If yes to #61, explain_____

62. Do other members of your immediate family have
any other problems with sleep? Yes No
If yes to #62, explain_____

63. Is there a history of crib death (SIDS) in your family? Yes No

**Medical and Surgical History**

64. Please list your current medical problems, such as high blood pressure, heart disease, stroke, lung disease, etc. and surgeries over last 10 years ( if you need more than 6 lines please continue on back of page.)
    A. _____
    B. _____
    C. _____
    D. _____
    E. _____
    F. _____

**Psychological History**

65. Do you feel depressed?
    Never_____ rarely_____ occasionally_____ frequently_____ always_____
66. Do you feel depressed now? Yes No
67. Have you had a personality change?
    If yes to #67, describe_____
68. Have you ever seen a psychiatrist or any other type of counselor? Yes No
    If yes to #68, are you currently seeing a Psychiatrist or a counselor Yes No

**Medications and Drugs**

69. Please list below the name and dose of all medications you are taking and state how often and for wh reason you take each one. If you take no medications write N/A or if you take more than 6 please continue on the back of this page.

| NAME | DOSE | HOW OFTEN | FOR WHAT REASON |
|---|---|---|---|
| A. _____ | | | |
| B. _____ | | | |
| C. _____ | | | |
| D. _____ | | | |
| E. _____ | | | |
| F. _____ | | | |

70. Have you ever smoked cigarettes? Yes No
71. Do you currently smoke cigarettes? Yes No
If yes to #70 and no to #71, when did you quit? _____
If yes to #70 and no to #71, give an estimate of average packs of cigarettes smoked per day while you were smoking _____ and number of years of cigarette smoking _____
72. Have you ever smoked cigars? Yes No Currently? Yes No
73. Have you ever chewed tobacco? Yes No Currently? Yes No
74. Have you ever smoked a pipe? Yes No Currently? Yes No

Please fill in the chart below cups/day
75. Caffeinated Coffee ___/___
76. Decaffeinated Coffee ___/___
77. Caffeinated Soft Drinks ___/___
78. Do you currently smoke marijuana or take any other mood altering illicit drugs? Yes No
If yes to #78, what and how often _____
79. Do you currently drink alcohol? Yes No
If yes to #79, on the average, how many alcoholic drinks (1 glass of wine, 1 shot of liquor, or 1 bee Is 1 drink) do you drink on:
Weekdays (working days) _____
Weekend (non working days) _____
80. Have you ever felt annoyed by others when they have expressed Concerns regarding your drinking Yes No
81. Have you ever felt guilty about your drinking? Yes No
82. Have you ever had the need to drink in the morning as an eye opener? Yes No
83. Do you ever have a drink just before going to sleep? Yes No
84. Have you ever had the need to cut down on your alcohol? Yes No
85. Do you have any other comments about your sleep?

_____

_____

_____

_____

*Thank you for your cooperation in answering this questionnaire.*