

NAME: _____ DATE: _____

THIS INFORMATION BECOMES A PART OF YOUR **CONFIDENTIAL** MEDICAL RECORD

PLEASE COMPLETE THIS FORM COMPLETELY TO ASSURE A THOROUGH EVALUATION. PLEASE GET INPUT FROM SOMEONE WHO SHARES YOUR BEDROOM IF AT ALL POSSIBLE.

LEAVE THIS SECTION BLANK (FOR OFFICE USE ONLY)

What time do you **usually** go to bed (average) on a weekday (workday or schoolday)? _____ AM PM
 What time do you **usually** attempt to fall asleep (average) on these days _____ AM PM
 How long does it **usually** take you to get to sleep once you begin trying (average) on these days? _____ Min Hrs

How often have you noticed the following problems when you are trying to go to sleep?	Never	Not in past month	Less than once/wk	1 – 2 times/wk	3 – 6 times/wk	Every night
Hallucinations (e.g. seeing people who are not really there)						
Body jerking just as you are falling asleep?						
Leg cramps which keep you from getting to sleep?						
Pain that keeps you from getting to sleep? Location:						
Thought racing or mind just won't "shut off" to allow sleep?						
Intense, irresistible, urges to move your legs?						

If "Yes" to the last question, please answer the following lettered questions. (If "No", please go on to the next numbered question.)
 A. Are the urges worse towards the evening or at night? Yes No _____
 B. Are the urges worse at rest and improved by walking, rubbing, or stretching the legs? Yes No _____
 C. How long have you been noticing these urges? _____
 D. Do these urges occur at least twice a week? Yes No Comments: _____
 E. Are these urges bothersome enough to keep you from falling asleep rapidly? Yes No

On weekends or days off" what time do you usually go to bed (average)? _____ AM PM
 On these days what time do you usually attempt to fall asleep (average)? _____ AM PM

How do you sleep when away from home? _____ Worse Better Same
 Are you reported to snore at all? Yes No

How often do you (or others) notice the following about you during sleep:	Never	Rarely	1 – 2 times/wk	3 – 4 times/wk	5 – 7 times/wk	Don't know
Snorting or gasping?						
Loud snoring?						
Breathing stops, choke or struggling for breath?						
Waking suddenly with shortness of breath?						
Sweating?						
Hot flushing of your skin that wake you from sleep?						
Heartburn or stomach fluids coming up into the throat?						
Leg cramps that wake you up out of sleep?						
Leg jerking or twitching?						
Sleep talking?						
Sleep walking?						
Nightmares?						
Physical movements or speech which mimics your dreams?						
Violent behavior during dreams, harmful to yourself or others?						
Fearful waking without remembering dreams (sleep terrors)?						
Episodes of hot flashes or flushes that wake you?						
Difficulty returning to sleep because the mind is too active?						
Waking because of pain? Where:						
Waking because of numbness or tingling? Where:						
Stopping breathing for short periods of time?						

How likely are you to doze off or fall asleep in each situation on the right, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of those things recently, try to work out how they would have affected you. Use the following scale to check (✓) the most appropriate box for each situation.

SITUATION	Chance of Dozing			
	Never	Slight	Moderate	High
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 to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes in the traffic				

Do you notice any seasonal changes in your mood? Yes No Unsure If so, what changes do you notice?

These questions are about how you feel and how things have been with you **during the past week**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the **past week** -

	All of the Time	Most of the Time	A Good bit of the Time	Some of the Time	A Little of the Time	None of the Time
Have you felt calm and peaceful?						
Have you felt downhearted and blue?						

Have you had any of the following problems in the PAST MONTH (please check yes or no)?

	YES	NO		YES	NO		YES	NO
Fainting or near-fainting			SWELLING OF FEET OR ANKLES			URINATION AT NIGHT		
Flip-Flopping in the Chest			SHORTNESS OF BREATH			Number of times per night:		
Rapid Fluttering in the Chest			IRREGULAR MENSTRUAL PERIODS			TOOTH PAIN		
Pounding in the Neck						JAW JOINT PROBLEMS		

Do you have any sudden and temporary episodes of weakness (both sides of your body) when you are provoked by strong waves of emotion such as when hearing or telling a joke, when angry, or while laughing? Yes No If so, do you remain conscious and remember the entire experience? Yes No If so, do the episodes last less than a few minutes? Yes No If so, have you taken imipramine or clomipramine successfully to combat these episodes? Yes No

Have you had any of the following conditions or operations (please check yes or no)?

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE			DIABETES			PROSTATE SURGERY		
HEART ATTACK			THYROID PROBLEMS					
HEART MURMUR			ORTHODONTICS/ BRACES					
ENLARGED HEART			TONSILS REMOVED(T& A)			HEAD INJURY		
HEART SURGERY			HYSTERECTOMY			EPILEPSY OR SEIZURES		
ANEMIA			NASAL SURGERY			STROKE		
IRON DEFICIENCY			EMPHYSEMA			DEPRESSION		
DENTURES: PARTIAL? FULL?			ASTHMA			ALCOHOLISM		
			DEVIATED NASAL SEPTUM			PSYCHIATRIC TREATMENT		
			HOLE IN EAR DRUM			CHILDHOOD SLEEP PROBLEMS		

Has your thyroid level (blood test) been checked within the past year? (circle one) Yes No Unsure

If you did have blood thyroid tests, were they normal? (circle one) Yes No Unsure

PLEASE LIST ANY PAST SURGERIES OR ILLNESS NOT MENTIONED ABOVE:

Has one or more of your family members (blood relatives) been affected by any of the following illnesses:

Illness	Family Member(s)	Illness	Family Member(s)	Illness	Family Member(s)
RESTLESS LEGS		INSOMNIA		SLEEP APNEA	
NARCOLEPSY					

Please list the medications that you usually take, including "over-the-counter" medications, vitamins, herbal preparations, and caffeine pills such as "No Doz". You may attach a list if this is easier for you.

MEDICATION	Dose	Times per Day	MEDICATION	Dose	Times per Day

Have any of the your medications caused or worsened your fatigue or sleepiness or insomnia? Yes No
If so which ones?

Please list any other medications not listed above (include street drugs such as cocaine and marijuana):

Please check all that apply:

ALCOHOL:	Never drink	Rare	< 1 drink/day	1-2 drinks/day
	> 2 drinks/day	Alcohol problem	Recovering alcoholic - Years of sobriety:	

Cigarettes:	Never smoked	Still smoking	Years of smoking:	Packs per day:
	Quit smoking	Years since quitting:		

Please list all previous REACTIONS or ALLERGIES to medications if any:

MEDICATION	REACTION/ALLERGY	MEDICATION	REACTION/ALLERGY

What is your current height? _____ Feet _____ Inches What is your current weight? _____ Pounds
 What was your weight one year ago? _____ Pounds What was your weight at age 20? _____ Pounds

Any other problems you wish to discuss?

LEAVE THIS NEXT SECTION BLANK (FOR OFFICE USE ONLY)

BP /	R L brachial	<input type="checkbox"/> sitting <input type="checkbox"/> lying	NECK	<input type="checkbox"/> Normal <input type="checkbox"/> Goiter <input type="checkbox"/> Adenopathy
EYES	<input type="checkbox"/> Ø exm'd <input type="checkbox"/> Full EOM <input type="checkbox"/> Pupils ERRLA	<input type="checkbox"/> Fundus:	<input type="checkbox"/> Carotid bruit R L None	Circ: _____ cm.
EARS	<input type="checkbox"/> Ø exm'd <input type="checkbox"/> NI <input type="checkbox"/> Perf TM	<input type="checkbox"/> Retained mucus	OCCLUSION	<input type="checkbox"/> Class I <input type="checkbox"/> Class II <input type="checkbox"/> Class III
NASAL MUCOSA	<input type="checkbox"/> Normal <input type="checkbox"/> Pale <input type="checkbox"/> Swollen	<input type="checkbox"/> Blood R L B	TEETH UP:	<input type="checkbox"/> Normal <input type="checkbox"/> Crowded <input type="checkbox"/> Denture: full partial
TURBINATES	<input type="checkbox"/> Normal <input type="checkbox"/> Enlarged	R L B	LOW:	<input type="checkbox"/> Normal <input type="checkbox"/> Crowded <input type="checkbox"/> Denture: full partial
SEPTUM	<input type="checkbox"/> Normal <input type="checkbox"/> Dev. R L <input type="checkbox"/> Perforated		TONGUE	<input type="checkbox"/> Normal <input type="checkbox"/> Enlarged <input type="checkbox"/> High <input type="checkbox"/> Other:
COLUMELLA	<input type="checkbox"/> Normal <input type="checkbox"/> Dev. R L		HRD PALATE	<input type="checkbox"/> Normal <input type="checkbox"/> High <input type="checkbox"/> Torus palatinus
LUNGS	<input type="checkbox"/> Normal		SFT PALATE	<input type="checkbox"/> Normal <input type="checkbox"/> Low <input type="checkbox"/> Asymm <input type="checkbox"/> Red <input type="checkbox"/> Truncated MM CLASS: _____
ABDOMEN	<input type="checkbox"/> Normal <input type="checkbox"/> Tender <input type="checkbox"/> Bruit		UVULA	<input type="checkbox"/> NI <input type="checkbox"/> Lng <input type="checkbox"/> Absent <input type="checkbox"/> Thick <input type="checkbox"/> Thin <input type="checkbox"/> Bifid <input type="checkbox"/> Edema
HEART	<input type="checkbox"/> Normal <input type="checkbox"/> C R OS M <input type="checkbox"/> Irregular S ₃ S ₄	P ₂ > A ₂ P ₂ = A ₂ P ₂ < A ₂	PALAT. TONS	<input type="checkbox"/> Ø seen <input type="checkbox"/> Vestigial R L <input type="checkbox"/> Enlarged R L <input type="checkbox"/> Kissing
CRANIAL NERVES	<input type="checkbox"/> Ø exm'd <input type="checkbox"/> II - XII Screened and intact		PHARYNX	<input type="checkbox"/> Normal <input type="checkbox"/> Narrowed: AP Lat <input type="checkbox"/> Other:
			PHYSIOGNOMY ¹	<input type="checkbox"/> Normal <input type="checkbox"/> Recessed chin <input type="checkbox"/> Long face
			EXTREM	<input type="checkbox"/> No CCE <input type="checkbox"/> Edema: R L A PT Tr 1 2 3 4
			REFLEXES	Right: BRrad /4 Bicep /4 Knee /4 Ankle /4
				Left: BRrad /4 Bicep /4 Knee /4 Ankle /4
<input type="checkbox"/> Other:				<input type="checkbox"/> motor restlessness

DIFFERENTIAL DIAGNOSIS

PLANS AND ORDERS

COUNSELLING

<input type="checkbox"/> OSA	<input type="checkbox"/> Idopath hypersom	<input type="checkbox"/> HSR or PSG	<input type="checkbox"/> MWT	<input type="checkbox"/> Diff Diagnosis/diagnostic options
<input type="checkbox"/> Insom, idiop	<input type="checkbox"/> Insom, pscophy	<input type="checkbox"/> HSR	<input type="checkbox"/> MSLT	<input type="checkbox"/> Potential health risks of Ø Rx
<input type="checkbox"/> Restless Legs	<input type="checkbox"/> Leg cramps	<input type="checkbox"/> PSG		
<input type="checkbox"/> RSBD	<input type="checkbox"/> Inadeq. Sleep hyg.	<input type="checkbox"/> Split	<input type="checkbox"/> PSG- CPAP	<input type="checkbox"/> Pathophysiology discussed
<input type="checkbox"/> Narcolepsy	<input type="checkbox"/> Insufficient sleep	<input type="checkbox"/> F/U	<input type="checkbox"/> OXIMETRY	<input type="checkbox"/> Rx options including Ø treatment
<input type="checkbox"/> DSPS	<input type="checkbox"/> Seas. aff. ds.	<input type="checkbox"/> Cognitive-behavioral therapy		<input type="checkbox"/> ? relat. of Dx results to symptoms
<input type="checkbox"/> Chron rhinitis	<input type="checkbox"/> Primary snoring	<input type="checkbox"/> Other		<input type="checkbox"/> Driving precautions discussed _____
<input type="checkbox"/> Seas rhinitis	Other:			