Northfield Hospital + Clinics

PDSinc.™

Patient label

Height: _____ Neck size: _____
Weight: _____ Weight 5 years ago: _____

MEDICAL HISTORY

Please check all that apply:

Did you ever have?

□ Diabetes □ High Blood Pressure
□ Asthma □ Emphysema
□ Thyroid Disease □ Kidney Disease
□ Stroke □ Migraines
□ Heart Attack □ Irregular Rhythm
□ Depression □ Seizures
□ Gastric Reflux □ Congestive Heart Failure
□ Fibromyalgia □ Rhinitis/Sinusitis
□ Angina □ Claustrophobia/Anxiety
□ Others: _____

SURGICAL HISTORY

Please list all surgeries, with dates:

□ Tonsils/Adenoids
□ Sinus/Nasal Surgery
□ Heart Surgery
□ Heart Angiogram/Stents
□ Others: _____

EPWORTH SLEEPINESS SCALE

0 = NEVER doze off
1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

Would you doze off while:	*Scale Rating*
Sitting and Reading	
Watching TV	
Sitting inactive in public place	
As a passenger in a car	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped in traffic	
TOTAL	

SOCIAL HISTORY

□ Single □ Married
□ Divorced □ Widowed

Do you have children? _____ How Old? _____

What kind of work? _____
I have a Commercial Driver's License
□ Yes □ No

SOCIAL EXPOSURES

Did you ever smoke? □ Yes □ No
How many packs/day? _____
Started at what age? _____
When did you quit? _____

Do you drink alcohol? □ Yes □ No
How much? _____
What time of day? _____
Were you ever an alcoholic? □ Yes □ No

Do you consume caffeine? □ Yes □ No
□ Coffee □ Pop □ Energy Drinks
How much? _____

Did you use illicit substances? □ Yes □ No
□ Meth □ Marijuana □ Others: _____
How much? _____

MEDICATIONS

Drug Allergies? □ Yes □ No
Please list: _____

Current Medication	Dose	Reason

Northfield Hospital + Clinics

PDSinc.™

SLEEP HISTORY

Please check all that apply:

□ Driving accidents or near accidents due to sleepiness
□ Significant weight gain
□ Snore
□ Awaken with choking sensation

□ Trouble falling asleep
□ Trouble remaining asleep
□ Awaken with intense anxiety
□ Feel depressed during the day

□ Legs jerk and kick during sleep
□ Uncomfortable leg sensations that improve with movement
□ Uncomfortable leg sensations always worsening in the evenings

□ Jaw aches in the morning
□ Grind teeth in sleep
□ Sleep Talking as an adult
□ Sleep Walking as an adult
□ Acting out your dreams
□ Nighttime seizures
□ Shift Work

□ Awaken to go to the bathroom
□ Awaken with back pain
□ Awaken with headaches
□ Awaken with heartburn or acid reflux
□ Awaken with cough or shortness of breath

□ Vivid dreams or hallucinations while awake
□ Paralysis or inability to move upon awakening
□ Sudden feeling of weakness in legs or knees

PREVIOUS SLEEP TREATMENT

I was previously diagnosed with?
□ Sleep Apnea □ Narcolepsy □ Restless Legs Syndrome
□ Other: _____

□ Prior Treatment
□ CPAP □ BiLevel □ Surgery
□ Other: _____

When? _____ Where? _____

SLEEP HISTORY

Please complete the following:

What time do you go to bed? _____
On days off: _____

How long before you fall asleep? _____
_____

How many times do you wake up during the night?
_____

How many times do you go to the bathroom during the night? _____

What time do you get out of bed in the morning?
_____
On days off: _____

Use an Alarm Clock? □ Yes □ No

What time do you have to get to work?
_____

Do you nap? □ Yes □ No
How long? _____

Do you doze off? □ Yes □ No
What time of day? _____

Anyone share your bed? □ Yes □ No

Do you sleep better on vacation (away from home?)
□ Yes □ No
Please explain _____

Do you exercise? □ Yes □ No
What kind? _____
What time of day? _____

Patient label

Use back if more space needed.