Barker
Sleep Institute
All we do is sleep.

SleepXcel
Sleep well, Play well.

SLEEP & MEDICAL HISTORY

Name: _____ Gender [ ] Male [ ] Female

Date of Birth: _____/_____/_____ Age: _____ Martial Status: _____

What is your main concern about your sleep? (If you do not have one, indicate why you were referred.) _____

How long has this been a problem? _____ weeks/months/years

List any/all physicians that you would like your records sent to including your PCP:

_____

How does it affect your life and daily activities and athletic ability? _____

_____

Have you had any previous evaluations, examinations, or treatments for this or any other sleep problems? Yes or No (Please explain) _____

_____

Please check all that apply to you:

[ ] Snore
[ ] Stop breathing while asleep
[ ] Wake gasping for breath
[ ] Night sweats
[ ] Headaches on awakening
[ ] Awaken with dry mouth
[ ] Nasal congestion
[ ] Irregular breathing
[ ] Fatigue
[ ] Awaken tired or sleepy

Briefly Describe: _____

[ ] Jerking/kicking during sleep or awake
[ ] Restless legs
[ ] Leg cramps during sleep
[ ] Urge to move legs when resting
[ ] Have to stretch or move legs
[ ] Disagreeable sensation in legs

Briefly Describe: _____

[ ] Difficulty falling asleep
[ ] Frequent waking
[ ] Early waking
[ ] Mind races, worries
[ ] Restless. Non restorative sleep
[ ] Trouble going back to sleep

Briefly Describe: _____

[ ] Sleepiness during work hours
[ ] Sleepiness driving
[ ] Sleepiness when quiet or resting
[ ] Decreased memory, focus, concentration
[ ] Weakness with laughter or strong emotion
[ ] Vivid dreams/ hallucination at sleep onset or waking
[ ] Paralysis at sleep onset or waking
[ ] Shift work schedule: _____
[ ] Insomnia with flying/changing time zones
[ ] Staying up and sleeping too late
[ ] Going to sleep and getting up too early

Briefly Describe: _____

Name: _____

[ ] Sleepwalking
[ ] Sleep talking
[ ] Sleep eating
[ ] Dream enactment
[ ] Teeth grinding
[ ] Bedwetting
[ ] Seizures in sleep
[ ] Disturbing dreams
[ ] Awaken screaming or fearful

Briefly Describe: _____

[ ] Changing practice/game times affects my sleep more when playing [ ] Day games [ ] Night games [ ] Both
[ ] Flying/changing time zones disturbs my sleep more when traveling [ ] East [ ] West [ ] Both
[ ] My sleep is poor quality or disrupted with flying [ ] During [ ] After [ ] Both
[ ] I prefer to stay up later and sleep later [ ] I prefer to go to bed earlier and get up earlier

Sleep Schedule

1. When is your typical time to go to sleep? Weekdays _____am/pm Weekends _____ am/pm

2. When is your typical time to get up? Weekdays _____am/pm Weekends _____ am/pm

3. What are your work hours? _____ Alternate work schedule _____

4. How long does it typically take you to fall asleep? _____

5. How many times do you usually awaken during the night? _____

6. What seem to be the reasons for awakening during the night? _____

7. How long does it usually take you to fall back asleep after these awakenings? _____

8. Do you find yourself waking too early? [ ] Never [ ] Rarely [ ] Occasionally [ ] Often [ ] Always

9. How long do you think you actually sleep during the night? Hours _____ Minutes _____

10. Do you take naps? [ ] Never [ ] Rarely [ ] Occasionally [ ] Often [ ] Always How long? _____

11. Besides sleeping & sex, what other activities do you do 30-60 minutes before sleep? [ ] Bedroom [ ] Other room
[ ] TV [ ] Exercise [ ] Read [ ] Eat [ ] Paperwork [ ] Computer [ ] Other _____

Medical/Surgical History

[ ] Allergies	[ ] Diabetic	[ ] Heart Arrhythmia	[ ] Reflux/GERD
[ ] Anemia	[ ] Emphysema	[ ] Heart Attack	[ ] Seizures
[ ] Anxiety	[ ] Easy Bruising	[ ] Heart Disease	[ ] Stroke
[ ] Arthritis	[ ] Easy Bleeding	[ ] Heart Failure	[ ] Thyroid Disease
[ ] Asthma	[ ] Fibromyalgia	[ ] Hepatitis B or C	[ ] Other
[ ] Cancer	[ ] Glaucoma	[ ] High Blood Pressure	_____
[ ] Chest Pain	[ ] Gout	[ ] Kidney Disease	_____
[ ] COPD	[ ] Headaches	[ ] Menopause	_____
[ ] Depression	[ ] Head Trauma	[ ] Parkinson 's disease	_____

[ ] Sinus Surgery [ ] Tonsillectomy/Adenoidectomy [ ] Nasal surgery [ ] Orthodontia (braces)
[ ] Other _____

List all medications you are taking: _____
_____

What medications have you taken to help you sleep? [ ] None _____

Medication Allergies or Adverse effects: [ ] NKDA [ ] Latex Allergy [ ] others: _____

Name: _____

Substance Use: Circle all that apply:

Caffeine: Coffee Sodas Tea Energy Drinks Time of day_____

Alcohol: Beer Liquor Wine Amount per day _____

Nicotine: Cigarettes Dip/chew Patch/ gum Current or past

Family Medical History

	Living	Deceased	Age now or at death	Current Health Problems or Cause of deatl
Father				
Mother				
Brother				
Sister				
Children				

Does anyone in your family have a history of any of the following?

	Snoring	Apnea	Narcolepsy	Insomnia	Restless Legs	Extreme Sleepiness
Father						
Mother						
Brother						
Sister						
Children						

Social History

Who lives in the same home with you? _____

Occupation? _____

Current Driver's license? [ ] Yes [ ] No

Your exercise consists of: _____

How often do you exercise and at what time of day? _____

Review of Systems Circle all that apply:

General/Constitutional (fever, weight loss or gain, tired feeling

Eyes (blurred vision, eye pain, discharge, etc)

Ears, Nose, Throat, Mouth (hearing, ear ache, congestion, cough, nasal drip, dry mouth.

Respiratory (asthma, wheezing, SOB, chronic Bronchitis

Cardiovascular (diabetic, hypertension, heart problems)

Gastrointestinal (diarrhea, constipation, hernia, ulcer)

Lymphatic (anemia, bleeding)

Musculosketal (arthritis, joint pain, muscle pain, Cramps, stiffness, swelling)

Skin (pimples, warts, growths, rashes)

Signature: _____ Date: _____

BarkerSleep
Medicine Professionals, PLLC

Epworth Sleepiness Scale

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How likely are you of being drowsy or fall asleep in the following situations, in contrast to feeling 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 most appropriate number for each situation.

Situation	Chance of being drowsy		
Sitting & Reading			
[ ] 0 would never doze	[ ] 1 slight chance of dozing	[ ] 2 moderate chance of dozing	[ ] 3 high chance of dozing
Watching TV			
[ ] 0 would never doze	[ ] 1 slight chance of dozing	[ ] 2 moderate chance of dozing	[ ] 3 high chance of dozing
Sitting, inactive in a public place			
[ ] 0 would never doze	[ ] 1 slight chance of dozing	[ ] 2 moderate chance of dozing	[ ] 3 high chance of dozing
As a passenger in car for an hour w/o a break			
[ ] 0 would never doze	[ ] 1 slight chance of dozing	[ ] 2 moderate chance of dozing	[ ] 3 high chance of dozing
Sitting & talking to someone			
[ ] 0 would never doze	[ ] 1 slight chance of dozing	[ ] 2 moderate chance of dozing	[ ] 3 high chance of dozing
Lying down to rest in the afternoon			
[ ] 0 would never doze	[ ] 1 slight chance of dozing	[ ] 2 moderate chance of dozing	[ ] 3 high chance of dozing
Sitting quietly after a lunch w/o alcohol			
[ ] 0 would never doze	[ ] 1 slight chance of dozing	[ ] 2 moderate chance of dozing	[ ] 3 high chance of dozing
In a car, while stopped for a few minutes in traffic			
[ ] 0 would never doze	[ ] 1 slight chance of dozing	[ ] 2 moderate chance of dozing	[ ] 3 high chance of dozing

Total: _____

Patient Name: _____ **Date:** _____

RV: 4/18/14