

Name: _____ Age: _____ Gender: Male Female

Date of Birth (month/day/year): ____/____/____ SSN: _____ - _____ - _____

Race: _____ Marital Status: Never married Married Divorced Widowed

Home Address: _____ City: _____ ZIP: _____

Daytime Phone: (____) _____ - _____ Evening Phone: (____) _____ - _____ Email: _____

How did you hear about us? _____

Goals of treatment: (please check all that apply)	
Elimination of snoring	<input type="checkbox"/>
Falling asleep faster	<input type="checkbox"/>
Better breathing during the night	<input type="checkbox"/>
Sleeping through the night	<input type="checkbox"/>
More restful sleep (improved sleep quality)	<input type="checkbox"/>
Better alertness and energy during the day	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>

Please describe your sleep problem(s) including both nighttime and next day symptoms: _____

How long have you had these problems? _____

Please describe any past professional evaluations or treatments for your sleep problems, including what was and was not helpful? _____

What have you tried on you own to improve your sleep and was it helpful? _____

Please check any of the following activities that you do in bed:

- Read Watch TV Eat Talk on the phone Listen to music
Write Argue Worry Watch the clock Use computer

How many pillows do you sleep with? _____

Is your bed and bedroom comfortable, dark and quiet? Yes No

Are you currently having to do shift work or work during the night? Yes No

Who is your current employer? _____

What is your current occupation/job title? _____

Who do you live with? _____

What types of exercise do you do? _____ How often? _____

Current height? _____ Weight? _____ Weight 1 year ago? _____ Weight 5 years ago? _____

What are your hobbies and interests? _____

Sleep Symptoms

When trying to sleep how often do you experience the following:	Daily	Weekly	Monthly	Rarely	Never
Difficulty <i>falling</i> asleep?					
Trouble <i>staying</i> asleep?					
Repeated awakenings?					
Waking up <i>too early</i> ?					
Snoring or trouble breathing?					
Choking or gasping for air?					
Leg, arm or body jerks?					
Other bothersome behaviors?					
Uncomfortable or painful sensations in legs					
Irresistible desire to move legs?					
Kept awake because of bed partner?					
Intense visual images when falling asleep?					

Awakening Symptoms

When waking up from sleep how often do you notice the following:	Daily	Weekly	Monthly	Rarely	Never
coughing or choking?					
shortness of breath?					
an irregular or rapid heart beat?					
nasal congestion or runny nose?					
stomach acid taste?					
heart burn?					
dry mouth?					
headache?					
anxious or panicky feeling?					
legs, arms or body moving or jerking?					
bed covers extremely messy?					
momentary confusion?					
vivid or frightening visual images?					
temporarily unable to move your body?					

Daytime Symptoms

During the day when you want to be alert and awake how often do you experience:	Daily	Weekly	Monthly	Rarely	Never
Feeling tired even after a full night's sleep					
Struggling to stay awake					
Difficulty concentrating					
Dozing off (even if for a second)					
Trouble remembering					
Stress, anxiety or sadness					
Avoiding social situations					
Not enjoying fun activities					
Daytime sleepiness					
Sudden muscular weakness with strong emotion					

Epworth Sleepiness Scale	
How likely are you to doze off or fall asleep in the following situations in contrast to just 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:	
Sitting and reading	
Would never doze <input type="checkbox"/> . Slight chance of dozing <input type="checkbox"/> . Moderate chance of dozing <input type="checkbox"/> . High chance of dozing <input type="checkbox"/> .	
Watching TV	
Would never doze <input type="checkbox"/> . Slight chance of dozing <input type="checkbox"/> . Moderate chance of dozing <input type="checkbox"/> . High chance of dozing <input type="checkbox"/> .	
Sitting inactive in a public place (theater, meeting, etc.)	
Would never doze <input type="checkbox"/> . Slight chance of dozing <input type="checkbox"/> . Moderate chance of dozing <input type="checkbox"/> . High chance of dozing <input type="checkbox"/> .	
As a passenger in a car for an hour without a break	
Would never doze <input type="checkbox"/> . Slight chance of dozing <input type="checkbox"/> . Moderate chance of dozing <input type="checkbox"/> . High chance of dozing <input type="checkbox"/> .	
Lying down to rest in the afternoon when circumstances permit	
Would never doze <input type="checkbox"/> . Slight chance of dozing <input type="checkbox"/> . Moderate chance of dozing <input type="checkbox"/> . High chance of dozing <input type="checkbox"/> .	
Sitting and talking to someone	
Would never doze <input type="checkbox"/> . Slight chance of dozing <input type="checkbox"/> . Moderate chance of dozing <input type="checkbox"/> . High chance of dozing <input type="checkbox"/> .	
Sitting quietly after lunch <i>without</i> alcohol	
Would never doze <input type="checkbox"/> . Slight chance of dozing <input type="checkbox"/> . Moderate chance of dozing <input type="checkbox"/> . High chance of dozing <input type="checkbox"/> .	
In a car, while stopped for a few minutes in traffic	
Would never doze <input type="checkbox"/> . Slight chance of dozing <input type="checkbox"/> . Moderate chance of dozing <input type="checkbox"/> . High chance of dozing <input type="checkbox"/> .	

Do you have a regular bed partner? Yes No

Bed Partner Questions										
If possible please have your bed partner (or anyone who has observed your sleep recently) help answer the below questions. They may observe changes the person sleeping cannot notice.										
When asleep do others observe:	Daily		Weekly		Monthly		Rarely		Never	
Snoring?										
Loud breathing or sighing?										
Breathing become labored?										
Long pauses between breaths?										
Breathing stop?										
Repeated kicking of legs?										
Repeated moving of arms?										
Thrashing or moving of the body?										
Teeth grinding?										
Sleep walking?										
Sleep talking?										
Other behaviors? Please describe:										
Do any of the above result in sleeping in separate beds?										
On a scale of 1-10 (10 being loudest) How loud can the snoring be?	1	2	3	4	5	6	7	8	9	10
Use the below space to have your bed partner describe any additional information, concerns or problems they feel should be included for evaluation: _____										

Sleep-Wake Schedule

The below questions about sleep and wake schedules recognize patterns can vary from day to day. Do not worry about being exact, these are just your best estimates.

<p>Do you keep a fairly regular schedule? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>What time do you go to bed? _____ AM/PM.</p> <p>What time do you get out of bed? _____ AM/PM.</p> <p>Once in bed how long does it take to fall asleep? _____.</p> <p>Once asleep, how many times do you wake up? _____.</p> <p>How much lost sleep from awakenings (in minutes)? Typical _____. Least _____. Most _____.</p> <p>What time do you get out of bed to start the day? _____ AM/PM.</p> <p>Number of hours of sleep at night? _____.</p> <p>Do you awaken refreshed and ready to begin the day?</p> <p> Always <input type="checkbox"/> Almost always <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/></p> <p>How long does it typically take until you are fully awake (in minutes)? _____.</p> <p>How often do you take naps? Daily <input type="checkbox"/> A few days a week <input type="checkbox"/> A few days a month <input type="checkbox"/> Rarely/Never <input type="checkbox"/></p> <p>If you nap, how long are your naps? _____.</p> <p>When you are free to choose your own schedule (vacations, weekends etc.), when do you prefer to go to sleep? _____ AM/PM. When do you prefer to wake-up? _____ AM/PM.</p>

Many commonly used substances can affect sleep. Please describe your use of the following over the last month.

If you drink **Caffeinated** beverages (including coffee, tea, sodas etc.) please list your daily consumption.

Weekday: _____ . **Weekend:** _____ .

If you drink **Alcoholic** beverages (including wine, beer, liquor) please list your daily consumption.

Weekday: _____ . **Weekend:** _____ .

If you use **Tobacco** products (include cigarettes, cigars, snuff, chew etc) list your daily use.

Weekday: _____ . **Weekend:** _____ .

Mood altering drugs including stimulants (such as cocaine, amphetamine), tranquilizers, and hallucinogens (including marijuana, LSD, or Ecstasy) can affect both sleep and daytime alertness. If you have tried such drugs please list and describe any effects on sleep or daytime alertness: _____

Family Medical History

Please list blood relatives (parents, siblings, children etc.) who snore, have daytime sleepiness, insomnia, or other sleep problems: _____

Please list blood relatives with medical or psychiatric disorders: _____

General Medical History

Do you currently have or have you ever been diagnosed with (check any that apply):

- | | | | | | |
|-------------------------|--------------------------|---------------------------|--------------------------|-----------------|--------------------------|
| High blood pressure | <input type="checkbox"/> | Elevated cholesterol | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> |
| Heart disease | <input type="checkbox"/> | Lung disease | <input type="checkbox"/> | Liver disease | <input type="checkbox"/> |
| Kidney disease | <input type="checkbox"/> | Head trauma or concussion | <input type="checkbox"/> | Reflux (GERD) | <input type="checkbox"/> |
| Neurologic disease | <input type="checkbox"/> | Seizure disorder | <input type="checkbox"/> | Immune disorder | <input type="checkbox"/> |
| Kidney disease | <input type="checkbox"/> | Thyroid disease | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | Fibromyalgia | <input type="checkbox"/> | Depression | <input type="checkbox"/> |
| Anxiety/ panic disorder | <input type="checkbox"/> | Drug abuse/dependence | <input type="checkbox"/> | Alcoholism | <input type="checkbox"/> |

Please list any other health problems: _____

Please list the names of healthcare providers for whom you are currently receiving care, or have seen in the past year (If possible include the city where they practice)_____

Please describe any past surgeries or hospitalizations:_____

Please list the medications, vitamins, herbs, and supplements you have taken in the last month. Please include both prescription and over-the-counter medications:				
Medication	Dosage	Frequency	Reason	Date started

Please describe any allergies, side effects or other adverse reactions to medications.
If none please write in "none:" _____

We are located in the HM Poole Medical Office Building
Scripps Memorial Hospital Campus, La Jolla

Driving Directions

From North County:

1. Take I-5 South to Genesee Avenue Exit.
2. At off ramp signal, turn LEFT (East).
3. Go to first traffic light (after passing freeway), TURN RIGHT into Scripps Hospital campus.
SEE PARKING DIRECTIONS BELOW.

From Greater San Diego

1. Take I-5 North to Genesee Avenue Exit.
2. At off ramp follow curve to the RIGHT (heading East on Genesee Avenue).
3. Go to first traffic light, TURN RIGHT into Scripps Hospital campus.
SEE PARKING DIRECTIONS BELOW.

From Interstate-805:

1. Take Miramar Road/La Jolla Village Drive Exit. Head West on La Jolla Village Drive.
2. TURN RIGHT onto Genesee Avenue.
3. Go one-mile (through several traffic lights).
4. Turn LEFT at signal into Scripps Hospital campus.
SEE PARKING DIRECTIONS BELOW.

Parking Directions

After entering the Scripps Campus drive to the parking gate and get a ticket.
At **SECOND** stop sign **turn RIGHT**. After two more stop signs (3rd & 4th),
you will see our 4-story building on the **RIGHT**:
"9834" HM Poole Medical Office Building.
Parking Structure is to your **LEFT**.

Parking Fee is \$3 with ticket validation from our office.

POOLE BUILDING

Directly across the street from the parking structure is the entrance to the Poole Building. Upon entering you will be on the Lobby Level (second floor). Our office is on the first floor, in Suite 112.

ELEVATOR

Take the elevator to Level 1.
Exit elevator **TURN LEFT**. Suite 112 is the first door on the right.

Please allow 5-minutes to park and walk to our office.

