ARIZONA SLEEP CENTER

Comprehensive Care For All Ages

Date:________________

Name:__________________________ DOB:____/____/________ Male ☐ Female ☐

Ask the patient to rate the chance of dozing based on the scale provided.

Record their response on a scale of 0-3 and sum the total.

Situation 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	**Chance of Dozing**			
	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
	0	**1**	**2**	**3**
Sitting and reading				
Watching TV				
Sitting, inactive, in a public place				
As a passenger in a car for an hour				
Lying down in the afternoon				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes in traffic				
TOTAL				

ARIZONA SLEEP CENTER

Comprehensive Care For All Ages

1. What is your major sleep problem?
2. What time do you fall asleep and what time do you wake up?
3. Do you take naps during the day? If yes, at what time and how long
4. Have you had any sleep study within the last 3 years?
5. Are you on any PAP therapy? ☐ Yes ☐ No
6. How many times do you typically wake up during sleep?
7. Do you move or yell during sleep? ☐ Yes ☐ No
8. Do you have vivid dreams and/or act out your dreams? ☐ Yes ☐ No
9. Have you ever fallen out of bed during sleep? ☐ Yes ☐ No
10. Do you have creepy sensations in your legs at night disturbing your sleep? ☐ Yes ☐ No
11. Any previous diagnosis of narcolepsy/idiopathic hypersomnia?
12. Have you ever used any sleep aid medications?
13. Have you ever had any Upper Airway Surgery for snoring or sleep apnea? ☐ Yes ☐ No
14. Have you ever used oral appliance therapy for snoring/sleep apnea? ☐ Yes ☐ No
15. Do you suffer from any of these past/current conditions?

☐ daytime sleepiness
☐ snoring
☐ witnessed apnea
☐ gasping of air
☐ headache
☐ dry mouth
☐ sore throat
☐ frequent nocturnal urination
☐ blood donation
☐ seizures
☐ depression
☐ lung disease
☐ chronic pain
☐ suicide ideation
☐ jaw clenching/TMJ
☐ atrial fibrillation
☐ pacemaker or defibrillator
☐ cardiac stent
☐ congestive heart failure
☐ oxygen use
☐ sinus/airway surgery
☐ tonsillectomy
☐ heavy periods
☐ kidney disease
☐ anxiety
☐ liver disease
☐ premature at birth
☐ chronic obstructive pulmonary disease
☐ CPAP/BiPAP usage
☐ diabetes
☐ mellitus
☐ high blood pressure
☐ asthma
☐ coronary artery disease
☐ anemia/iron deficiency
☐ stroke
☐ heart disease
☐ thyroid problems
☐ blood or bleeding disorders
☐ heart attack
☐ substance abuse

16. Marital Status? ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Not Answered
17. Exercise? ☐ Yes ☐ No
18. Caffeine Intake, At what time?
19. Occupation, Work hours?
20. Any history of Shift work? ☐ Yes ☐ No
21. Smoking? ☐ current smoker ☐ former smoker ☐ nonsmoker
22. What is the name of your DME Supplier, if you use CPAP/BiPAP Device?
23. Any Mask Leak or Pressure Issues with your PAP Device?
24. Do you clean your Mask,/Humidifier/chamber/hose etc.? ☐ Yes ☐ No

Do you have any medication allergies? Please make sure to have your medication list with you for your appointment.

Thank you!