SSM Health St. Mary's Hospital Sleep Disorder Center

400 N Pleasant Centralia. IL 62801

Date:_ __ Technician: _____ Neck Circumference _____

Name:___ _____ Height _____ft ___in Weight _____ Room _____

Referring MD:_ _____ Reason for Testing:___ _____

_____

Allergies: _____

Medications including over-the-counter: _____

_____

_____

Tobacco Use Yes/No ___Packs/Day Alcohol Use Yes/No Amount daily ____ weekly ____

Shift Worker Yes/No Work Hours _____ Claustrophobic Yes/No

Tonsillectomy Yes/No ENT Surgery Yes/No Laser Uvuloplasty Yes/No

Please circle if you are being treated or have been diagnosed with the following:

High Blood Pressure / Heart Disease / Diabetes / Stroke / Depression / COPD /

Excessive Daytime Sleepiness / Asthma

Previous Sleep Study Yes/No Location _____ Date: _____

On CPAP Yes/No CPAP Setting _____ Result of Previous Study _____

_____

How did you find out about our Sleep Disorder Center?

My Doctor / Newspaper / Health Fair / Radio / Friend

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Please Check Each Statement That Applies To You

1. ____ Do you have a Pacemaker/ Internal Defibrillator
2. ____ Do you have metal clips in your head for Aneurysm
3. ____ I Have been told that I snore
4. ____ I have been told that I stop breathing when I sleep
5. ____ I feel sleepy during the day, even when I sleep through the night
6. ____ I have high blood pressure
7. ____ I have been told that I am a restless sleeper
8. ____ I sweat excessively during the night
9. ____ I frequently wake up with headaches
10. ____ I am over weight or have gained weight
11. ____ I seem to be losing my sex drive
12. ____ I have trouble concentrating or remembering things
13. ____ I have difficulty falling asleep
14. ____ Thoughts race through my mind preventing me from falling asleep
15. ____ I wake up at night and cannot go back to sleep
16. ____ I wake up earlier than I would like
17. ____ I lie awake for a half an hour or longer before falling asleep
18. ____ I had trouble concentrating when I was in school
19. ____ When I am angry, surprised, or laugh, I feel like I am going limp
20. ____ I have fallen asleep while driving
21. ____ I feel like I am going around in a daze
22. ____ I have vivid dream-like scenes upon falling asleep or waking up
23. ____ I have fallen asleep when laughing or crying

24. ____ I have trouble at work because of sleepiness
25. ____ I have vivid nightmares soon after falling asleep
26. ____ Sometimes I fall asleep no matter how hard I try to stay awake
27. ____ I feel like I have to cram a full day into every hour to get everything done
28. ____ Sometimes I feel unable to move when I am waking up or falling asleep
29. ____ I experience muscle tension in my legs
30. ____ I have noticed or others have commented that parts of my body jerk
31. ____ I have been told that I kick at night
32. ____ My legs ache or I have a "crawling" sensation in my legs at night
33. ____ I have leg pain at night
34. ____ I can't keep my legs still, I have to move them
35. ____ I wake up with heartburn
36. ____ I have a chronic cough
37. ____ I use antacids almost every week
38. ____ I am hoarse in the mornings
39. ____ I wake up at night coughing and wheezing
40. ____ I have frequent sore throats
41. ____ I suddenly wake up gasping
42. ____ I usually go to bed at _____ and get out of bed at _____
43. ____ I am up to the restroom _____ times per night

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Use the following scale to choose the most appropriate answer for each of the following:

0 = would NEVER doze

1 = SLIGHT chance of dozing

2 = MODERATE chance of dozing

3 = HIGH chance of dozing

Sitting and reading _____

Watching TV _____

Sitting inactive in a public place (theater, meeting, etc) _____

As a passenger in a car for an hour without a break _____

Lying down to rest in the afternoon when able _____

Sitting and talking to someone _____

Sitting quietly after lunch without alcohol _____

In a car while stopped for a few minutes in traffic _____

TOTAL _____

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Below is a 1 Week Sleep Diary. Please keep track of your sleep habits for the days leading up to your sleep study.

Patient Name: _____ Date Started: _____

(Please Print)

DAY/DATE:	SUN	MON	TUES	WED	THUR	FRI	SAT
Time that you went to bed							
Time that you woke up							
Time you got out of bed for the day							
Duration of longest nap (in minutes)							
Number of times you woke up during night							
Approximate time that it took you to fall asleep							