Sleep Unlimited, Inc.- Sleep Disorders History and Physical		
FIRST NAME:	**MIDDLE:**	**LAST:**
Date of Birth _____ / _____ / _____ Age: _____	Date of Visit _____ / _____ / _____	
Referring M.D.	Primary M.D.	
Marital Status ☐ Single ☐ Married ☐ Divorced	Employment:	Handedness ☐ Right ☐ Left

Chief Complaint: Please briefly state in your own words the reason you are here for a sleep evaluation

For all sections below: **A check in the box denotes a "yes" to the described symptom; if "no", then do not check. Where applicable circle "Y" for yes or "N" for no.**

Sleep Symptoms:			
☐ Snoring	☐ Light	☐ Moderate	☐ Loud
☐ Snoring is so bad that spouse/bed partner sleeps in another room			
☐ Observed breathing pauses		☐ Awakenings from snoring	
☐ Sleep-related reflux (heartburn)		☐ Awakenings gasping for breath	
☐ Sinus congestion during sleep		☐ Kick legs during sleep	
☐ Sensations in legs make it difficult to fall asleep		☐ Breath through mouth/open mouth during sleep	
☐ Prominent sweating of upper chest & back during sleep			
☐ Morning headaches- if so how often?			

Sleep Habits: All times/numbers are average, can give range (Ex: 9-10 pm, etc.), no need to be overly exact.		
Bedtime (time to get in bed with the intention of falling asleep):		
Last time wake-up:	Use an alarm: ☐ Y ☐ N	
# awakenings during sleep period:	Most common reason:	
Once you decide you want to fall asleep, how long does it take?		
Estimated average hours sleep per night:	# naps per week:	Avg. duration:
If it takes greater than 30 minutes to fall asleep, what is the main reason? (Check below)		
☐ Racing thoughts ☐ Heartburn ☐ Planning out day's events	☐ Hearburn ☐ Spouse ☐ Breathing/snoring/snorting	☐ Pain ☐ Restless legs

Other:			
Do you watch TV in bed? ☐ Y ☐ N		Do you read in bed? ☐ Y ☐ N	
Do you watch the clock? ☐ Y ☐ N		Is your bedroom quiet? ☐ Y ☐ N	
Is your bedroom dark? ☐ Y ☐ N			
Do you turn on the light when you get up? ☐ Y ☐ N		Average time of evening meal:	
Primary Sleeping position:	☐ Supine (back)	☐ Lateral (side)	☐ Prone (on front)

Parasomnias / Seizures / Narcolepsy/RLS:			
☐ Sleep walking	☐ Sleep talking	☐ Sleep eating behavior	
☐ Act out dreams (particularly with violent imagery of fighting, etc.) with striking wall, table, bed partner, etc.			
☐ Seizures during sleep		☐ Awaken having bitten tongue	
☐ Dream-like hallucinations upon falling and or awakening from sleep			
☐ Sudden weakness and onset of sleepiness upon laughing, being startled, or extreme emotions			
☐ Do your have discomfort or bothersome sensations in your legs when inactive (Ex: passenger in the car, watching TV, relaxing before bedtime).			
Check appropriate description	☐ Burning ☐ Crawling	☐ Numb ☐ Jumping	☐ Ache ☐ Nervous
❑		❑	
❑		❑	

☐ Is the discomfort relieved by movement	☐ Does the sensation prolong sleep onset
☐ Do you kick your legs during sleep	❑

Past Medical History: Please check all *non-surgical* medical diagnoses that you have been given		
☐ None	☐ Hypertension	☐ Strokes
☐ Diabetes	☐ Heart attacks	☐ Rheumatoid arthritis
☐ Fibromyalgia	☐ Depression	☐ Liver disease
☐ Osteoarthritis	☐ High cholesterol	☐ Migraine headaches
☐ Epilepsy	☐ Parkinson's disease	☐ Gastroesophageal reflux
☐ Traumatic brain injury	☐ Cerebral aneurysm	☐ Brain tumor
☐ Meningitis	☐ Lupus	☐ Dementia
❑ Please list others:		

Past Surgical History (please write approximate year surgery was done)		
☐ Appendix removed	☐ Gall bladder removed	☐ Coronary bypass grafts
☐ Coronary stents	☐ Artery stents in legs	☐ Hernia repair
☐ Breast cancer	☐ Hiatal hernia repair	☐ Hysterectomy
☐ Tubal ligation	☐ Brain surgery	☐ Carpal tunnel
☐ Vertebral disc surgery	☐ Spinal fusion	☐ Brain (VP) shunt
Other (please list):		

Allergies- This is specific to food and drug allergies (not pollen, etc.). Please list type of reaction (i.e., rash, etc.).

Family History- List blood relatives with current health status and any illnesses they have had or have.					
Blood relative	Health Status	Present age	Age at death	Cause of death	Illnesses
Father					
Mother					
Brother					
Sister					
Children					

Social History				
☐ Single		☐ Married	☐ Divorced	☐ Widowed
# Daughters		Ages	#Sons	Ages
Occupation				
☐ Exercise (describe)				
Alcohol	☐ Never	☐ Beer #___ per d/w/mo.	☐ Wine #___ per d/w/mo.	☐ Liquor #___ per d/w/mo.
Smoking	☐ Never	#Packs per day	How many years?	Discontinued? ☐Y ☐N
Caffiene	☐ Never	# Coffee per day	#Colas per day	#Tea per day
Illicit drugs	☐ Cocaine	☐ IV	☐ Marijuana	☐ Amphetamines

Medications: