Houston Specialty Clinic

Pediatric Neurology | Pediatric Pulmonology | Pediatric and Adult Sleep Medicine
The Offices of Dr. Joshua Rotenberg, Dr. Sarat Susarla

Adult Sleep Medical History

Patient Name: DOB:

Adult Sleep

	Questions	Yes	No	Comments
1	Have you had sleep problems in the past?			
2	Have you had any sleep tests before?			
3	Do you snore loudly?			
4	Have you been told you hold your breath while sleeping?			
5	Do you wake up with a dry throat?			
6	Do you have night sweats?			
7	Do you need bathroom breaks after falling asleep?			
8	Do you wake up with headaches?			
9	Do you have choking spells during sleep?			
10	Does sleep position affect your snoring?			
11	Have you gained over 10 pounds in the last year?			
12	Do any (or did any) of your family members snore?			
13	Are you restless during sleep?			
14	Have you been told you kick or punch during sleep?			
15	Do you have leg discomfort relieved by movement?			
16	For women: Have you had problem pregnancies?			
17	Do you grind your teeth at night?			
18	Does your spouse/family/pets affect your sleep? Circle one			
19	Do you worry in bed?			
20	Do you check the clock frequently in bed?			
21	Do you watch TV in bed?			
22	Do you play video games or work on the computer before bed?			
23	Do you read in bed?			
24	Do you get suddenly weak and extremely emotional?			
25	Do you ever feel paralyzed for minutes on waking?			
26	On falling asleep or waking, have you ever noted hallucinations?			
27	Would you describe your sleep as refreshing?			
28	Do you need a minimum amount of sleep to feel refreshed?			
29	Did you have sleep problems as a child?			

Sleep times	AM	PM	Comments
What time do you try to go to sleep on weekdays?			
What time do you wake up on weekdays?			
What time do you try to go to sleep on weekends?			
What time do you wake up on weekends?			
What time do you take a nap, if applicable? Is the nap refreshing? Yes No			

Habits	Yes	No	Amount
Do you smoke cigarettes? E-Cigarettes/Jewel?			
Do you chew tobacco			
Have you quit nicotine products?			
If so, how long did you use and when did you quit?			Total years of use:_____ How long since you quit:_____
Do you drink alcoholic beverages?			
If so, what time is your last drink?			
Do you drink or eat caffeine/decaf products?			
If so, what time is the last product taken?			
Do you use, or have you used recreational/street drugs?			

	Do you have a medical history of:	Yes	No	Year Diagnosed
1	High blood pressure/hypertension			
2	Diabetes			
3	Heart disease or heart failure			
4	Kidney disease			
5	Stroke			
6	Obstructive lung disease or Asthma			
7	Heart rhythm, problems			
8	For women: Polycystic Ovarian disease			
9	Depression			
10	Anxiety			
11	Chronic pain			
12	Reflux disease or night time heartburn			
13	Seizures			
14	Thyroid disease			
15	Anemia			
16	Fibromyalgia			
17	Arthritis			

Any other medical conditions that you have been diagnosed with:

Please list sleep medications that have failed and why:

Medication name	Why it failed

Surgical History

Surgery performed	Date of surgery	Reason for surgery

Current Medications

		Time taken			
Name of medication	**Dose of medication**	**AM**	**PM**	**Bed**	**Other**

Medication Allergies

Name of medication	Type of reaction

Family Medical History

Please list any medical issues with members of your family.

Father	
Mother	
Brother	
Sister	
Son	
Daughter	
Paternal Grandfather	
Paternal Grandmother	
Maternal Grandfather	
Maternal Grandmother	

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Review of Systems

During the past few weeks, have you had any of the following symptoms? Please check all that apply.

Constitutional	○ Fever ○ Fatigue	○ Unexpected weight loss or gain ○ Night sweats	○ Loss of appetite ○ No general complaints	
Sleep:	○ Problems with sleeping ○ Breathing difficulties ○ Excessive sleepiness during the day	○ Dry mouth/sore throat upon awakening ○ Frequent awakening during the night ○ Other sleep difficulties	○ Snoring ○ Choking/gasping during sleep ○ Morning headaches ○ Difficulty falling asleep	○ Excessive movements during sleep ○ No sleeping problems
Eyes:	○ Dry eyes ○ Eye pain	○ Watery eyes ○ Itchy eyes	○ Vision changes	
Ears, Nose, and Mouth	○ Nasal congestion ○ Nasal discharge ○ Ear discharge ○ Bad breath ○ Recurrent strep throat	○ Sinus pressure ○ Nose bleeds ○ Dry mouth ○ Postnasal drip ○ Sensation of fluid or fullness in ear	○ Facial pain ○ Ear pain ○ Tooth pain ○ Nasal ulcers ○ Oral ulcers	○ Sore throat ○ Enlarged tonsils ○ No complaints
Heart:	○ Chest pain ○ Shortness of breath	○ Palpitations ○ Swelling in the legs	○ Racing heart ○ No complaints	
Lungs:	○ Shortness of breath at rest ○ Shortness of breath with exercise	○ Cough with sputum production ○ Blood tinged phlegm or coughing up blood	○ Shortness of breath with normal daily activities ○ Wheezing	○ Cough without sputum production ○ No lung complaints
Stomach and Intestines	○ Nausea ○ Abdominal pain ○ Vomiting	○ Diarrhea ○ Constipation ○ Heartburn	○ Constipation ○ Jaundice ○ Abdominal fullness	○ No complaints
Genito-Urinary System:	○ Painful urination	○ Blood in urine	○ Urgent or frequent urination	○ No complaints
Muscles and Joints:	○ Join pain ○ Muscle aches	○ Joint swelling ○ Muscle weakness	○ Joint stiffness ○ No complaints	
Neurological System:	○ Headaches ○ Vision changes	○ Difficulty with memory ○ Seizures	○ Weakness ○ Tremors	○ Sensory changes ○ No complaints
Psychiatric:	○ Depression	○ Anxiety	○ Panic Attacks	○ No complaints
Hematologic and Lymphatic System:	○ Easy bruising ○ Easy bleeding	○ History of blood clots (DVT) ○ Blood clot antibody	○ Swollen lymph nodes ○ No swollen lymph nodes	○ No complaints
Endocrine and metabolism:	○ Heat intolerance Cold intolerance	○ Frequent need to urinate ○ Always thirsty	○ Intermittent vision changes	○ Problems with thyroid ○ No complaints
Skin:	○ Eczema (dry/itchy skin)	○ Sun Sensitivity ○ Psoriasis	○ Hives ○ Rash	○ No complaints
Allergy and Immunology:	○ Anaphylaxis	○ Angiodema	○ Frequent infections	○ No complaints

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Social History

Please tell us about the patient's environment and social situation. Please check all that apply.

Patient's living environment:

○ House ○ Apartment ○ Trailer home ○ Central A/C ○ Window A/C units ○ Dehumidifier ○ Humidifier	○ Changes air filters regularly ○ Hypoallergenic mattress encasement(s) ○ Stuffed animals in the bedroom	○ Carpet throughout the home ○ Upholstered furniture ○ Drapes/curtains on the windows ○ Hypoallergenic pillow encasements	○ Carpet in the bedroom ○ Mildew/mold problems in the home ○ Wood or leather furniture ○ Blinds on the windows

Does the patient drink alcohol, or is there alcohol consumption in the patient's environment?

○ Daily ○ Less than once a month	○ Weekly ○ Special occasions only	○ Monthly ○ None

Does the patient smoke or is the patient exposed to smoke?

○ Less than 1 pack per day	○ 1 pack per day ○ Greater than 2 packs per day	○ 1-2 packs per day ○ Second hand smoke exposure	○ Snoke exposure in the home/car ○ No smoke exposure

Who lives in the home with the patient?

○ Both parents ○ Siblings	○ Only mom ○ Only dad	○ Spouse ○ Children	○ Foster parent(s) ○ Other

What type of work does the patient (or patient's parents) do?

○ Professional ○ Work in the home	○ Medical field ○ Laboratory work	○ Exposure to toxins and/or chemicals	○ Hard labor ○ Other

Has the patient traveled or lived outside the United States?

○ Yes	○ No

What is the patient's (or patient's parents) marital status?

○ Single	○ Married	○ Divorced	○ Other

Is the patient exposed to pet(s) or animals? If so, how many?

○ Dogs (#)_____ ○ Cats (#)_____	○ Birds (#)_____ ○ Cattle(#)_____	○ Horses (#) _____ ○ No pet/animals

Does the patient attend school?

○ Elementary ○ Middle ○ High School	○ College ○ Not in school	○ Involved in organized sports	○ Does not play sports ○ Involved in extra-curricular activities

Does the patient (or patient's family) have the daycare exposure?

○ Yes	○ No