ELI HENDEL M.D.
Pulmonary and Sleep Specialist

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SLEEP AND MEDICAL HISTORY

Have you ever had a sleep study before? _____

If yes, do you know what the diagnosis or conclusion was?

_____

Have you ever used CPAP or BiPAP before? _____

Are you currently using CPAP or BiPAP? _____

If yes, do you know what the pressure setting is? _____

Briefly decribe your sleep problem:

_____

_____

_____

_____

Sleep Patterns:

	What time do you typically go to bed?	What time do you typically wake up?
Workday		
Weekend / Vacation		

- How long does it take you to fall asleep? _____
- How many times a night do you wake up? _____ To urinate? _____
- Have you been told that you snore? ❑ No ❑ Mild ❑ Moderate ❑ Loud
- Have you been told that your breathing stopsor pauses when you sleep? ❑ Yes ❑ No
- Do you wake up gasping or choking? ❑ Yes ❑ No

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Do you wake up with a headache? ❑ Yes ❑ No

Are you sleepy during the day? ❑ Yes ❑ No

Do you fall asleep at inappropriate times, such as at meetings, the movies, riding in a car, etc? ❑ Yes ❑ No

Have you ever been involved in a car accident due to falling asleep behind the wheel? ❑ Yes ❑ No

Do you take naps during the day? ❑ Yes ❑ No

How many? _____ How long do they last? _____

Do you have a restless, uncomfortable or creeping feeling in your legs that is alleviated by walking or moving? ❑ Yes ❑ No

Do your legs or arms kick or "jerk" throughout the night? ❑ Yes ❑ No

Do you ever grind you teeth at night? ❑ Yes ❑ No

Has your weight changed recently? ❑ Yes ❑ No

- Gained _____ lbs. Lost _____ lbs.
- When/Over what period of time? _____

Do you ever use sleeping pills? ❑ Yes ❑ No

If yes, how many days of the month do you typically use them? _____

Please list all sleeping pills and doses (if you know them) of all sleeping pills that you have used:

_____

_____

Estimate, for an average day, your daily consumption of:

Coffee _____ Tea _____ Soda with caffeine _____

Have you ever smoked cigarettes? ❑ Yes ❑ No

Age when you started smoking? _____

Age when you quit smoking? _____

How many packs per day? _____

When was your last cigarette? _____

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EPWORTH SLEEPINESS SCALE

How likely are you to **DOZE** or F**ALL ASLEEP** in the following situations, in contrast to feeling just 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 to.

Use the following scale to choose the most appropriate number for each situation:

0	=	would **never** doze
1	=	**slight** chance of dozing
2	=	**moderate** chance of dozing
3	=	**high** change of dozing

SITUATION

Sitting and reading _____

Watching TV _____

Sitting, inactive in a public place. (*For example, a theater or a meeting.*) _____

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

Lying down to rest in the afternoon when circumstances permit _____

Sitting and talking to someone _____

Sitting quietly, after a lunch without alcohol _____

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

TOTAL _____