HORIZON Gastroenterology & Neurology
Our Patients, Our Priority

Name ____ Social Security No. ____________________________
Last First MI

Address ____ Phone No. (_____) ____________________________

City ____________________ State _______ Zip ____________ Secondary No. (_____) ___________________________

Date of Birth ______________ Sex (M/F) _____ Race __________ Email _______________________________________

County ___________________ Primary Care _________________________ Marital Status Single Divorced Married Widowed

Employer ____ **Occupation** __________________________

Employer Phone No (_____) ______________________

INSURANCE INFORMATION (Please notify us if your insurance has changed)

Insurance Company ____ I.D No. _______________________________

Group No. __________________ Effective Date _______________ Specialty Copay Visit: _________________________

Subscriber ____ Patients Relationship to Subscriber _____________
Last First MI

Secondary Insurance____ I.D. No. _______________________________

Group No. __________________ Effective Date _______________ Specialty Copay Visit: _________________________

Subscriber ____ Patients Relationship to Subscriber _____________
Last First MI

Height:____________ Weight:____________

Occupation: __________________________________ Usual Work Hours/Days: ________________

Referring Physician: ___________________________ Family Physician (PCP): _________________

Marital status: Single Married Divorced Widowed

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.

My Main Sleep Complaint(s) Is:

____
____
____

Trouble sleeping at night For how many months/years? ____________________________

Being sleepy all day For how many months/years? ____________________________

Snoring For how many months/years? ____________________________

Unwanted behaviors during sleep, explain: ____

____

Sleep Pattern

Work Days (Weekday)

Typical bedtime:_________ a.m./p.m. typical wakeup time_________ a.m./p.m.

Off days, weekends

Typical bedtime:_________ a.m./p.m. typical wakeup time_________ a.m./p.m.

Typical amount of time it takes to fall asleep: _______________ _______________

Typical number of awakenings per night: _______________ _______________

List any activities that you normally do during nighttime awakening(s),

i.e., restroom, eat, watch TV: ____

Typical amount of time to fall back asleep

after an awakening: _______________

How do you usually awaken,

i.e., alarm clock?: ________________

Typical time you get out of bed: ______________a.m./p.m.

Total amount of sleep per night:______________

Number of naps per day: ______________

Please check all of the following statements that are true about your sleep:

Sleep Habits

I usually watch TV or read in bed prior to sleep
I often travel across 2 or more time zones
I drink alcohol prior to bedtime
I smoke prior to bedtime or when I awaken during the night
I eat a snack at bedtime
I eat if I wake up during the night
I typically wake up from sleep to go to the bathroom
I have trouble falling asleep
I often wake up during the night
I am unable to return to sleep easily if I wake up during the night
I have thoughts that start racing through my mind when I try to fall asleep
I wake up early in the morning, and I am still tired but unable to return to sleep
I have nightmares as an adult
I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep
I sweat a great deal during sleep
I cannot sleep on my back

Breathing

I wake up at night choking, smothering or gasping for air
I have been told that I snore
I have been told that I snore only when sleeping on my back
I have been awakened by my own snoring/Restlessness
I have been told that I stop breathing while I sleep
I have uncomfortable feelings in my legs and/or arms when I lie down at night
I have to move my legs or walk to relieve the uncomfortable feelings in my legs
I am a restless sleeper
I have been told that I kick or jerk my legs and/or arms during sleep
I have a hard time falling asleep because of my leg movements
I have talked in my sleep as an adult
I have walked in my sleep as an adult
I grind my teeth in my sleep

Daytime Sleepiness

I take daytime naps
I have a tendency to fall asleep during the day
I have had “blackouts” or periods when I am unable to remember what just happened
I have fallen asleep while driving
I have had auto accidents as a result of falling asleep while driving
I fall asleep while watching TV
I fall asleep during conversations
I fall asleep in sedentary situations
I performed poorly in school because of sleepiness
I have had injuries as the result of sleepiness
I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
I have had an inability to move while falling asleep or when waking up
I have had hallucinations or dreamlike images or sounds when falling asleep or waking up
I drink caffeinated beverages during the day: _____cups/bottles/cans per day

Habits: Do you smoke?

If Yes:	What?	Amount per Day	For How Many Years
	Cigarettes	___________ pack(s)	___________ years
	Cigars	___________ cigars	___________ years
	Tobacco	___________ pipes	___________ years

Do you drink alcohol? Circle answer Yes No

If Yes: What?	Frequency	Amount per Week
Beer	Daily Weekends Rare	________ cans/week
Wine	Daily Weekends Rare	_____ glasses/week
Liquor	Daily Weekends Rare	______ shots/week

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Social History

Sleep alone

Share a bed with someone

Share a bedroom, but have separate beds

Share a dwelling, but have separate bedrooms

Employment Status: Employed Unemployed Retired

My job requires driving a vehicle

I work with dangerous equipment or substances

I am a shift worker on rotating shifts

I am a permanent or long-term, third-shift worker

I am currently a student

Medical History

Vital Statistics

What is your: Height? _________ feet _________inches Weight? ______ pounds

Neck Size: ___________

What was your weight one year ago? ______ pounds Five years ago? ______ pounds

Current Medications

Medication Dose # Times per DayMedication

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Allergies: ____

Are you currently taking any sleep medications? Yes___ No___

If yes what medication? ____.

Are you taking medications for your blood pressure? Yes____ No ____

If yes how many medications are you taking for your blood pressure? ______

Have you ever had a stroke? Yes _____ No _____

Have you ever been diagnosed with Atrial Fibrillation or PVC's/ Arrhythmia? Yes___ No ___

Have you ever been diagnosed with Congestive Heart Failure? Yes___ No ___

Have you ever been diagnosed with Coronary Heart Disease/had a Heart Attack or Stent Placement? Yes___ No____

Do you have an A.I.C.D (automatic implantable cardioverter defibrillator?) or pacemaker? Yes___ No___

Are you a Diabetic? Yes___ No ___

Are you a smoker? Yes___ No___

Have you ever had Epilepsy or Seizures? Yes____ No____

Have you been diagnosed with Emphysema/COPD/Chronic Bronchitis/Asthma? (Please circle all that apply)

Are you on home Oxygen? Yes___ No___

Last Physical Exam: ________________________________

Special Needs (allergies): ____

Past Sleep Evaluation and Treatment

I have had a previous sleep disorder evaluation

I have had a previous overnight sleep study

I have had a daytime nap study

I have been prescribed a CPAP or bilevel PAP machine for home use

I have had surgical treatment for a sleep disorder

I have previously been prescribed medication for a sleep disorder

I have previously been treated for a sleep disorder

Do you currently use a CPAP machine? Yes____ No ____ what pressure are you on? ________

Are you a shift worker? Yes____ No____

How did you hear about us? ____

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EPWORTH SLEEPINESS SCALE

Name: ____

Today's Date:______________________________ **Date of Birth:**_____________________________________

How likely are you to doze off or fall 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 estimate how they would affect you.

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* chance of dozing

Situation	Chance of Dozing or sleeping
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. 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 the traffic	

1. Do you snore? ___ YES ___ NO
2. Do you wake up gasping? ___ YES ___ NO
3. Do you wake up several times during the night? ___ YES ___ NO
   If yes, Why? ____
4. Do you move your legs a lot at night? ___ YES ___ NO