REHAB MD

Sleep History and Exam

Your physician requests that you complete this Sleep History Form. This form evaluates the need for you to have a user-friendly home sleep test. The home sleep test will determine if you have a sleep disorder. Sleep disorders negatively affect your well-being, especially your cardiovascular health. Sleep disorders can be treated effectively.

Date: _____Name: _____ Date of Birth_____
Phone Number _____Physician Name: _____
Home Address_____

BMI ☐

1. Have you ever been given a CPAP device?(date_____)..... Yes ___ No___
2. Are you comfortable with your CPAP and satisfied with its use?..... Yes___ No___
3. How many hours do you sleep on average per night? Less than 4h……More than 4 h ……

Epworth Sleepiness Scale

How likely are you to doze off while doing the following activities? Please use the following scale:
0 = never, 1 = slight, 2 = moderate, 3 = high. Circle one of the following numbers

1. Being a passenger in a motor vehicle for an hour or more. …….. 0 1 2 3
2. Sitting and talking to someone…… 0 1 2 3
3. Sitting and reading…….. 0 1 2 3
4. Watching TV……... 0 1 2 3
5. Sitting inactive in a public place……. 0 1 2 3
6. Lying down to rest in the afternoon……..... 0 1 2 3
7. Sitting quietly after lunch without alcohol…….. 0 1 2 3
8. In a car, while stopped for a few minutes in traffic……. 0 1 2 3

Total ESS: ____

Part 1

1. Have you been told that you snore, grind your teeth at night?..... Yes___ No___
2. Do you wake up unrefreshed or tired, feeling sleepy most of time or need to nap?.....Yes___No___
3. Does your family have a history of premature death in sleep?..... Yes___ No___
4. Do you have diabetes?..... Yes___ No___
5. Have you ever been told you have coronary artery disease?..... Yes___ No___
6. Do you have high blood pressure?..... Yes___ No___
7. Have you ever experienced irregular heart rhythms?..... Yes___ No___
8. Do you have heart disease? …… Yes___ No___
9. Do you have lung disease? ……... Yes___ No___
10. Do you suffer from depression, anxiety, insomnia? …….. …… Yes ___No___
11. Do you take sleep medication? …….. …….. Yes___ No___
12. Do you experience morning headaches? ……..Yes___ No___
13. Do you take pain medication? ……..Yes___ No___
14. Do you suffer from restless legs syndrome? …… Yes___ No___
15. Do you suffer from ED, decreased libido, nocturia?……. ……Yes___No___
16. Do you suffer from decreased concentration, memory loss, impaired cognition…..... Yes___No___

Part 1 score: ____

Part 2

1. Have you ever been diagnosed with sleep apnea? …….. Yes___ No___
2. Do you awaken from sleep with chest pain or shortness of breath?.... Yes___ No___
3. Has anyone said that you seem to stop breathing while sleeping? ….. Yes___ No___
4. Is your neck size larger than 15" (female) or 16.5'' (male)…… Yes___ No___
5. Have you ever had a stroke?..... Yes___ No___
6. Have you ever been told you have congestive heart failure?..... …. Yes___ No___
7. Do you have or did you ever have atrial fibrillation?..... Yes___ No___
8. Do you wake up from sleep choking or gasping for air?..... Yes___No___
9. Do you wake up or bother bed partner with legs kicking or moving?... Yes___No___
10. Do you sleep walking, talking, acting out dreams?..... ….Yes___No____

Part 2 score: _____

Total score: _____

Patient Signature: _____ Date: _____
If patient presents with positive screening for sleep apnea a home sleep study will be ordered ☐
Physician Signature:_____ Date:_____
Mallampati score:_____Teeth marks on the tongue_____Overbite or recessive chin_____

Actual Neck Size: