YOUR FAMILY MEDICAL
KEEPING YOUR FAMILY WELL

SLEEP HISTORY AND EXAMINATION FORM

☐ Bedford
☐ Lewisville
☐ Benbrook
☐ Justin
☐ Boyd

Your physician requests that you complete this Sleep History Form which 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:_____ Age:_____

Phone:_____Home Address:_____

Physician Name:_____ Height_____ Weight____lbs. BMI_____

1) Have you ever been given a CPAP device? ☐Yes ☐No (Date_____)
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 4 hrs. ☐More than 4 hours

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

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

Part I

1)	Have you been told that you snore or grind your teeth at night?	☐Yes ☐No
2)	Do you wake unrefreshed, tired, feeling sleepy most of the 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?	☐Yes ☐No

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11) Do you take sleep medication? ☐Yes ☐No
12) Do you experience morning headaches? ☐Yes ☐No
13) Do you take sleep medication? ☐Yes ☐No
14) Do you suffer from restless leg syndrome? ☐Yes ☐No
15) Do you suffer from insomnia? ☐Yes ☐No
16) Do you suffer from narcolepsy? ☐Yes ☐No

PART II

1) Have you ever been diagnosed with sleep apnea? ☐Yes ☐No
2) Do you wake 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 even have atrial fibrillation? ☐Yes ☐No
8) Do you wake up from sleep choking or gasping for air? ☐Yes ☐No
9) Do you wake or bother bed partner with legs kicking or moving? ☐Yes ☐No
10) Do you sleep walk, talk, or act out dreams? ☐Yes ☐No

Actual Neck Size

Patient Signature: _____ Date:_____

If patient presents with positive screening or sleep apnea a home sleep study will be ordered. ☐

Physician Signature: _____ Date:_____

Mallampati Score: _____ ☐Teeth marks on tongue ☐Overbite or recessive chin