Name: _____

North Kansas City Hospital

History

1. What is your main concern regarding your sleep? (Why did your doctor order a sleep study?): _____

   _____

2. Have you had a previous Sleep Study? Yes No in a Sleep Lab at home

   If yes, when, and where was your study done? _____

3. Have you ever worn **CPAP/BiPAP**? Yes No Setting ____cm H2O Mask Type: Nasal Pillows Full face

   If yes, do you still have your machine? Yes No Where do you get your supplies? _____

   If yes, are you currently using it? Yes No If you quit, how long ago? _____

4. Are you currently on **oxygen**? Yes No How many liters? How long?

   Is it prescribed as continuous? N/A Yes No with Exertion? Yes No at Night? Yes No

5. Have you ever had a seizure or been diagnosed with a seizure disorder? Yes No If yes, when? _____

6. Have you had an Echocardiogram? Yes No If yes, when? _____ Where? _____

7. In the past 4-6 weeks, have you had eye or ear surgery? If planning to have it, when? _____ Yes No

8. Within the last year, has depression, anxiety, or stress interfered with your sleep? Yes No

9. Have you lost interest in sex, or have you had trouble functioning sexually? N/A Yes No

Fall Risk Assessment

10. Are you unsteady when standing or walking? Yes No Do you worry about falling? Yes No

11. Have you fallen in the past 6 months? Yes No How many times? _____

12. Do you use anything to assist you in walking? Yes No If yes, what do you use? _____

Throughout your Day

13. Do you suffer from morning headaches? Yes No How often? _____

14. Do you feel tired, sleepy and/or fatigued? Yes No

15. Do you struggle to concentrate? Yes No Have a feeling your mood is poor? Yes No

16. Any nicotine intake? Yes No

17. Do you drink caffeinated beverages within 5 hours of bedtime? Yes No

18. Do you consume Alcohol within 2 hours of bed? Yes No If yes, how often: Daily Weekly Monthly Rarely

19. Does your job require shift work? Yes No If yes, what time? From _____ AM / PM to _____ AM / PM

20. Does your job require you to have this test? Yes No

21. Have you been diagnosed with Restless Leg Syndrome or feel the need to move your legs around? Yes No

22. Do you feel a sudden weakness in your knees, neck, jaw, or arms with emotions? Yes No

Bed Activities

23. What time do you go to bed? _____ AM / PM What time do you get up to start your day? _____ AM / PM

24. Where do you sleep? Bed Recliner Other: _____ Do you sleep elevated? Yes No

25. While asleep do any of the following occur?

    Snoring Excessive Movements Physically acting out dreams Sleep Talking Yelling

26. How long does it take you to fall asleep initially? _____

    If you have trouble falling asleep, what occurs? _____

Name: _____

27. Do you wake up at night? Yes No How many times? ___ How long do awakenings last? _____
    What causes the awakening? _____ Activity during these awakening(s) _____
28. Do you awaken gasping, wheezing, short of breath, or feeling that you cannot breathe? Yes No
29. Do you feel like you cannot move when you first wake up? Yes No
30. Do you experience very vivid dreams, regularly? Yes No
31. Do you see or hear things that you know are not real when lying in bed? Yes No

Primary Care Practitioner: _____

Medications
Please list all your current medications (including over the counter), **if you do not have a paper copy list:**

_____
_____
_____
_____

Medication Allergies _____

Latex allergy Yes No **Adhesive/Tape Allergy** Yes No _____

Additional Notes/Comments_____
_____
_____

STOP-BANG Questionnaire

The following questions access your risk for Obstructive Sleep Apnea.

S-SNORING	Do you snore loudly? (louder than talking)	No	0	Yes	+1
T-TIRED	Do you often feel tired, fatigued, or sleepy during the daytime?	No	0	Yes	+1
O-OBSERVED	Has anyone observed you stop breathing during sleep?	No	0	Yes	+1
P-BLOOD PRESSURE	Do you have (or are you being treated for) high blood pressure?	No	0	Yes	+1
B-BMI	Body Mass Index, > 35 kg/m^2?	No	0	Yes	+1
A-AGE	Age over 50 years old	No	0	Yes	+1
N-NECK	Neck circumference > 40 cm (16 inches)	No	0	Yes	+1
G-GENDER	Born as a male?	No	0	Yes	+1

Total # Answered Yes _____

Epworth Sleepiness Scale

The Epworth Sleepiness Scale helps determine excessive sleepiness that may indicate a sleep problem, which could require medical attention. In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Use the following scale to rate your chance of doze off or fall asleep for each: **0 = never 1 =slight/ low 2 = moderate/medium 3 = high**

Situation	**Chance of dozing**
1. Sitting and reading	_____
2. Watching television	_____
3. Sitting inactive in a public place (theater, meeting, etc...)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest (nap) in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car, while stopped, for a few minutes in traffic	_____
Total Score	_____