PATIENT SLEEP-PHYSICAL HISTORY

Patient name:_________________________________ Test Date: ____/____/____

Sleep History:

	Yes	No
Has anyone ever told you that you snore?		
Has anyone ever told you that you stop breathing in your sleep?		
Do you ever wake up choking or gasping, or unable to catch your breath?		
Are you a restless sleeper (toss and turn)?		
What time do you retire for bed? ______am/pm What time do you start your day? _______am/pm		
Do you have difficulty falling asleep?		
How long does it take for you to fall asleep? _______________ minutes / hours		
How often do you wake during sleep? ____________________ times		
How many times do you get up to use the bathroom at night? ________________ times		
Has anyone ever told you that you grind your teeth while asleep?		
Has anyone ever told you that you kick your legs while asleep?		
How many pillows do you sleep with? __________________________		
Has anyone ever told you that you talk, mumble or yell while asleep?		
How many hours of sleep do you get, on average, each night? _______________ hours		
Are you tired during the day?		
Do you wake in the morning feeling refreshed?		
Do you wake in the morning with headaches?		
Have you noticed your mood, memory or concentration deteriorating?		

Medical History:

☐Diabetes ☐High Blood Pressure ☐Asthma ☐Stomach Problems ☐Back Pain
☐Leg Pain ☐History of Smoking) ☐Cardiac ☐Allergies ☐Latex Allergy
☐Other (specify below):

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List all **MEDICATIONS** this patient is currently taking: (use back of sheet or attach list if necessary)___

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