Seattle Sleep Medicine
Dr. Joe Albert
22315 Highway 99 N., Suite 1
Edmonds, WA 98026
(425) 771-3266 • www.SeattleSleepMedicine.com

Patient's Name: _____ Height: _____ *feet* _____ *inches* Weight: _____ *pounds*

Answering these questions could save your life or the life of someone you love!

Have you had a sleep study done? ☐Yes ☐No If so, when & where? _____

Life saving questions, please answer to the best of your ability	Yes	Seldom	Never	Not Sure
Do you wake up tired and unrefreshed?	☐	☐	☐	☐
Have you or your bed partner observed that you stop breathing or grasp for breath while sleeping?	☐	☐	☐	☐
Do you doze off while watching TV, driving, reading, or performing daily activities?	☐	☐	☐	☐
Do you snore?	☐	☐	☐	☐
Do you ever wake up out of breath or choking?	☐	☐	☐	☐
Are you a restless sleeper?	☐	☐	☐	☐
Do you have backaches?	☐	☐	☐	☐
Do you have headaches? If so, how often? _____	☐	☐	☐	☐
Do you have indigestion or acid reflux?	☐	☐	☐	☐
Do you have or have you ever had high blood pressure?	☐	☐	☐	☐
Have you had or have you ever had heart problems?	☐	☐	☐	☐
Do you have night sweats?	☐	☐	☐	☐
Do you have a history of depression?	☐	☐	☐	☐
Jump when going to sleep?	☐	☐	☐	☐
Carpal Tunnel Syndrome?	☐	☐	☐	☐
Have you had a change in weight?	☐	☐	☐	☐
Do you have dreams?	☐	☐	☐	☐
Do you clinch or grind your teeth at night?	☐	☐	☐	☐
Do you have TMD (Temporomandibular joint dysfunction-disorder - TMJ) symptoms?	☐	☐	☐	☐
Do you have Fibromyalgia or Chronic Fatigue Syndrome?	☐	☐	☐	☐
Other? _____	☐	☐	☐	☐

Sleep, Snoring and Apnea History:

1. About how many times per night do you wake up? _____

2. What time do you normally go to bed? _____

3. Of the hours you are in bed, about how many hours are you asleep? _____

4. Rate the quality of your sleep: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

5. What professional advice or treatment have you received for your snoring or sleep apnea?

Sleep Information - *continued*

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This refers to daily life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale and choose the most appropriate number for each situation:

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 moments in traffic ____

0 = Would **never** doze

1 = **Slight** chance of dozing

2 = **Moderate** chance of dozing

3 = **High** chance of dozing

General:

When did your symptoms first appear?

Was there a specific incident, accident or injury that seemed to trigger your symptoms?

Do your present symptoms affect relationships with family and friends? Is so, how?

What are your expectations in seeking treatment at this time?

What do you see yourself doing after treatment that you are not able to do now?

Sleep Center Evaluation:

☐ Yes ☐ No 1. Have you been diagnosed or treated for a sleep disorder? If so, when? _____

☐ Yes ☐ No 2. Have you had an evaluation at a sleep center?

Sleep Center Name: _____

Doctor's Name: _____

Location: _____

Sleep Study Date: _____

CPAP History (Please respond to this section ONLY if you have tried using CPAP):

Do you wear a CPAP device successfully during sleep? ☐ Yes ☐ No If yes, how many hours per night do you wear your CPAP? _____

If you are unable to wear a CPAP device, please check the reasons below for your difficulty.

- ☐ Mask Leaks
- ☐ Unable to get masks to fit properly
- ☐ Straps-headgear cause discomfort
- ☐ Does not seem to be effective
- ☐ Latex allergy
- ☐ Claustrophobia
- ☐ Disturbed or interrupted sleep caused by the presence of the device
- ☐ Noise disturbs my sleep and-or bed partner's sleep
- ☐ Restricts movement during sleep
- ☐ Pressure on the upper lip causes tooth related problems
- ☐ Unconsciously remove the device during sleep

Other Therapy Attempts:

Have you tried other therapies for your sleeping disorder? If yes, please list: (e.g. Weight-loss attempts, smoking cessation, surgeries, etc.)

Print Form