Hendricks Regional Health

Please bring this with you on the night of your test.

HENDRICKS REGIONAL HEALTH
Sleep Disorders Center
1000 E. Main St., Danville, IN 46122
Phone: (317) 745-3680
Fax: (317) 718-4027

Name:_____ Phone:_____
Address: _____ Your age:_____
_____ Height: _____ Weight:_____lbs

Doctor who referred you to our lab? _____
Family Doctor ? _____Address?_____

Have you ever had a sleep test before? YES NO If yes, where? _____When?_____

Please check those statements that are true for you

____ I feel I get too little sleep regardless of how long I stay in bed.

____ I have problems falling asleep and then staying asleep

____ I often have "restless" or "disturbed" sleep

____ I have frightening dreams or nightmares

____ I tend to lie awake with thoughts racing through my head

____ I awaken at the slightest noise

____ I have been known to sleep walk

____ I have been known to talk in my sleep

____ I grind my teeth during sleep (my jaw hurts in the mornings)

____ I get up to the bathroom more than once during the night

____ I sweat excessively when sleeping

____ I wake up with a headache in the morning

____ I have neck, spine, muscle, or joint pain during the night

____ When I'm angry or surprised, I feel as though my body goes limp

____ I have vivid nightmares or dreams upon falling asleep

____ I feel as though I'm hallucinating when I fall asleep

____ I snore in my sleep

____ I wake myself up choking or gasping for air during the night (or someone has observed this)

____ I feel paralyzed when falling to sleep

____ I have had a sleep problem since childhood

____ I am a night shift or swing shift worker

____ I take a daytime nap most days

____ I have gained weight (10% above usual) ____ I have lost weight (20 lbs or more)

____ My ankles swell during the day

____ I have chest pains at night ____ I have daytime chest pains

____ I am hearing impaired ____ I am vision impaired

____ Never smoked (have not had at least 100 cigarettes during lifetime)

____ Current everyday smoker (have had at least 100 cigarettes in lifetime and smoke everyday)

____ Periodic smoker (have smoked 100 cigarettes in lifetime, and still currently, but periodically)

____ Former smoker (have had at least 100 cigarettes in lifetime, but do not currently smoke)

____ I drink more than 3 caffeinated drinks per day

____ I have a parent or sibling with a sleeping disorder

____ I kick or jerk my legs at night.

____ I wake up during the night with heartburn-like symptoms

If a woman: _____ Menstrual cycles are regular. _____ Menstrual cycles are irregular.

_____ I am Pregnant. _____ I have menopausal symptoms now or am past them

I have a medical condition: (Check those that apply)

____ high blood pressure ____ seizures ____ reflux (GERD) ____ diabetes

____ depression ____ anxiety ____ COPD ____ arthritis

____ heart disease ____ cancer ____ stroke ____ Restless Leg Syndrome (RLS)

other diagnosed medical conditions:_____
_____

____ I have been diagnosed with obstructive sleep apnea

If on CPAP/BIPAP at home: Current home setting:_____cmH2O. Home Care Co:_____

If on oxygen therapy at home: Current liter flow setting:_____LPM Day Night Both

EPWORTH SLEEPINESS SCALE

How likely are you to fall asleep in the following situations? Use this scale to choose the most appropriate response:

0=would never doze
1=slight chance of dozing
2=moderate chance of dozing
3=high chance of dozing

_____ Sitting and reading

_____ Watching TV

_____ Sitting inactive in a public place (ex. Movie theater)

_____ As a passenger in a car for an hour without a break

_____ Lying down to rest in the afternoon

_____ Sitting talking to someone

_____ Sitting quietly after lunch (without alcohol)

_____ In a car while stopped for a few minutes in traffic

How do you wish your sleep to improve:_____
_____
_____

Medication Name and Dosage	Reason for Taking	Prescribing Doctor	Time Last Taken

List any Known Allergies_____