PENN SLEEP MEDICINE

Your Name: _____ Date of Birth: _____ Today's Date: _____

Referring and/or Primary Care Physician: _____

Please check if you FREQUENTLY experience any of the following symptoms:

CONSTITUTIONAL
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Night Sweats

ALLERGIES
- ☐ Seasonal Allergies

HEENT
- ☐ Nasal Congestion
- ☐ Difficulty Swallowing
- ☐ Hearing Loss
- ☐ Nosebleeds
- ☐ Teeth Grinding
- ☐ Wear Dentures

EYES
- ☐ Vision Loss
- ☐ Double Vision
- ☐ Dry Eyes

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Leg Swelling
- ☐ Short of Breath when lying flat

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Chest Tightness
- ☐ Wheezing
- ☐ Supplemental Oxygen use

GI
- ☐ Heartburn
- ☐ Bowel problems

HEME
- ☐ Bleeding
- ☐ Easy Bruising

GU
- ☐ Urinary Frequency
- ☐ Incontinence
- ☐ Waking up to urinate
- ☐ Erectile Dysfunction
- ☐ Menstrual problems
- ☐ Menopause

MUSCULOSKELETAL
- ☐ Joint Pain
- ☐ Muscle Cramps or Pain
- ☐ Neck/Back Pain
- ☐ Leg Discomfort

SKIN
- ☐ Itching
- ☐ Rash
- ☐ Dry or Sensitive Skin
- ☐ Hair Loss

ENDOCRINE
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Increased Thirst

NEUROLOGIC
- ☐ Headaches
- ☐ Numbness
- ☐ Involuntary Movements
- ☐ Hallucinations
- ☐ Dizziness
- ☐ Speech Problems
- ☐ Muscle Weakness
- ☐ Memory Loss
- ☐ Balance Problems

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Claustrophobia
- ☐ Panic Attacks

IN THE PAST YEAR:

Have you had any surgeries or hospitalizations? ☐ No ☐ Yes _____

Have you had any changes in your medical problems? ☐ No ☐ Yes _____

Have any family members had changes in their health or been diagnosed with a sleep disorder? ☐ No ☐ Yes

Have your work duties (especially driving) or work hours changed? ☐ No ☐ Yes _____

Have you had any accidents due to falling asleep while driving? ☐ No ☐ Yes _____

If you are using CPAP/BiPAP, are you benefiting from ongoing use? ☐ Yes ☐ No _____

Other sleep comments: _____

PLEASE LIST:

How many cups of: Coffee/day_____ Tea or iced tea/day_____ Sodas/day_____

How many alcoholic drinks/day_____ Work status: _____

Usual bedtime_____ Do any of the following delay sleep? ☐ Restless legs ☐ Pain ☐ Anxiety

Time to fall asleep: ☐ Brief ☐ Variable _____Minutes _____Hours

Cause and number of awakenings per night_____ ☐ Bathroom ☐ Pain ☐ Don't know ☐ Other_____

Length of awakenings per night_____ ☐ Brief ☐ Variable _____Minutes _____Hours

Alarm is usually set for: _____ ☐ No Alarm

Out of bed on weekdays at: _____ Out of bed on weekends at: _____

Naps: ☐ None ☐ Weekdays From_____ to _____ From_____ to _____
☐ Weekends From_____ to _____ From_____ to _____

Additional comments: _____

MD/NP/RN Review: _____ Date:_____ Time:_____