

NORTHERN INDIANA NEUROLOGICAL INSTITUTE

Patient name _____
 Date of birth _____ Age _____
 Usual bedtime _____
 Usual wake time _____

Date: _____
 Collar/neck size _____ inches
 Pregnant Yes _____ No _____

Patient's Main Complaint: _____

Have you had a previous bone density test for osteoporosis (DEXA scan)? Yes _____ No _____

Sleep Complaint? Yes No If yes, explain: _____

Previous Accidents/Injuries: _____

PAST MEDICAL HISTORY

| | | Date of Diagnosis | | | Date of Diagnosis |
|------------------------|----------------------------------------------------|-------------------|-------------------------|----------------------------------------------------|-------------------|
| Allergies/Hayfever | <input type="radio"/> Yes <input type="radio"/> No | _____ | Liver disease | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Alzheimer's disease | <input type="radio"/> Yes <input type="radio"/> No | _____ | Lung disease/asthma | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Arthritis | <input type="radio"/> Yes <input type="radio"/> No | _____ | Meningitis/encephalitis | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Cancer | <input type="radio"/> Yes <input type="radio"/> No | _____ | Multiple sclerosis | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Diabetes | <input type="radio"/> Yes <input type="radio"/> No | _____ | Osteoporosis | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Elevated cholesterol | <input type="radio"/> Yes <input type="radio"/> No | _____ | Parkinson's disease | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Elevated triglycerides | <input type="radio"/> Yes <input type="radio"/> No | _____ | Seizures/epilepsy | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Heart arrhythmia | <input type="radio"/> Yes <input type="radio"/> No | _____ | Sinus disease | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| (Type if known _____) | | | Stroke | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Heart disease | <input type="radio"/> Yes <input type="radio"/> No | _____ | Thyroid disease | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| High blood pressure | <input type="radio"/> Yes <input type="radio"/> No | _____ | Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Kidney disease | <input type="radio"/> Yes <input type="radio"/> No | _____ | Ulcers/GERD | <input type="radio"/> Yes <input type="radio"/> No | _____ |

PAST HOSPITALIZATIONS AND SURGERIES

| Description | Dates | Description | Dates |
|-------------|-------|-------------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

CURRENT MEDICATIONS

| Name | Dose | Name | Dose |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Are you allergic to any foods or medications? Yes No If yes, please list: _____

Do you or have you used any prescription or over-the-counter medications to help you sleep (i.e., Ambien, Benadryl, Tylenol PM, etc)?
 Yes No If yes, please list: _____

REVIEW OF SYSTEMS

Do you or have you had any of the following symptoms:

- | | | | | | |
|----------------------------|---------------------------|--------------------------|-------------------------------|---------------------------|--------------------------|
| Headache | <input type="radio"/> Yes | <input type="radio"/> No | Lack of energy | <input type="radio"/> Yes | <input type="radio"/> No |
| Nausea | <input type="radio"/> Yes | <input type="radio"/> No | Blackouts or fainting | <input type="radio"/> Yes | <input type="radio"/> No |
| Vomiting | <input type="radio"/> Yes | <input type="radio"/> No | Shortness of breath | <input type="radio"/> Yes | <input type="radio"/> No |
| Double vision | <input type="radio"/> Yes | <input type="radio"/> No | Chest pain | <input type="radio"/> Yes | <input type="radio"/> No |
| Blurred vision | <input type="radio"/> Yes | <input type="radio"/> No | Coughing | <input type="radio"/> Yes | <input type="radio"/> No |
| Loss of vision | <input type="radio"/> Yes | <input type="radio"/> No | Joint pain | <input type="radio"/> Yes | <input type="radio"/> No |
| Weakness | <input type="radio"/> Yes | <input type="radio"/> No | Palpitations | <input type="radio"/> Yes | <input type="radio"/> No |
| Numbness/tingling in limbs | <input type="radio"/> Yes | <input type="radio"/> No | Swelling of legs | <input type="radio"/> Yes | <input type="radio"/> No |
| Pain in leg(s) | <input type="radio"/> Yes | <input type="radio"/> No | Difficulty walking | <input type="radio"/> Yes | <input type="radio"/> No |
| Dizziness | <input type="radio"/> Yes | <input type="radio"/> No | Frequent infections | <input type="radio"/> Yes | <input type="radio"/> No |
| Weight loss | <input type="radio"/> Yes | <input type="radio"/> No | Depression | <input type="radio"/> Yes | <input type="radio"/> No |
| Poor coordination | <input type="radio"/> Yes | <input type="radio"/> No | Abdominal pain | <input type="radio"/> Yes | <input type="radio"/> No |
| Hearing difficulty | <input type="radio"/> Yes | <input type="radio"/> No | Difficulty with bowel/bladder | <input type="radio"/> Yes | <input type="radio"/> No |
| Ringing in the ears | <input type="radio"/> Yes | <input type="radio"/> No | Bloody or black stool | <input type="radio"/> Yes | <input type="radio"/> No |
| Swallowing difficulty | <input type="radio"/> Yes | <input type="radio"/> No | Bloody urine | <input type="radio"/> Yes | <input type="radio"/> No |
| Speech difficulty | <input type="radio"/> Yes | <input type="radio"/> No | Menstrual difficulty | <input type="radio"/> Yes | <input type="radio"/> No |
| Tremors or shaking | <input type="radio"/> Yes | <input type="radio"/> No | Circulation problems | <input type="radio"/> Yes | <input type="radio"/> No |
| Convulsions | <input type="radio"/> Yes | <input type="radio"/> No | Difficulty thinking | <input type="radio"/> Yes | <input type="radio"/> No |
| Head injury | <input type="radio"/> Yes | <input type="radio"/> No | Memory loss | <input type="radio"/> Yes | <input type="radio"/> No |
| Back or neck pain | <input type="radio"/> Yes | <input type="radio"/> No | Change in taste | <input type="radio"/> Yes | <input type="radio"/> No |
| Change in smell | <input type="radio"/> Yes | <input type="radio"/> No | | | |

SOCIAL HISTORY

Occupation: _____ Shift Work: Yes No Retired Yes No Date: _____

Marital status: Single Married Widowed Divorced Other _____

Do you have children? Yes No If yes, how many? _____

On average, how much alcohol do you drink per day?
(If less than 1 drink per day, enter 0)

| | |
|-------|------------------------------|
| _____ | Cans of beer |
| _____ | Ounces of liquor |
| _____ | Glasses of wine (4 oz/glass) |

On average, how much of the following caffeine products do you drink in a day?
(If less than 1 drink per day, enter 0)

| | |
|-------|------------------------------------------------------------------|
| _____ | Cups of coffee |
| _____ | Cups of tea |
| _____ | Cans of soda (i.e., Pepsi, Coke, Dr. Pepper, Mountain Dew, etc.) |

Do you presently smoke cigarettes? Yes No Packs per day _____

Did you smoke in the past? Yes No Date quit _____

Have you, do you, use marijuana? Yes No How much? _____

Have you, do you, use cocaine? Yes No How much? _____

Have you, do you, use illicit IV drugs? Yes No How much? _____

PATIENT NAME: _____ DATE: _____

FAMILY HISTORY

Do you have any siblings? Yes No Number of: _____ Brothers _____ Sisters

Has any of your blood (immediate) family suffered from:

- | | | | |
|---------------------------------|----------------------------------------------------|----------------------|----------------------------------------------------|
| Snoring | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy | <input type="radio"/> Yes <input type="radio"/> No |
| Sleep apnea | <input type="radio"/> Yes <input type="radio"/> No | Cancer | <input type="radio"/> Yes <input type="radio"/> No |
| Insomnia | <input type="radio"/> Yes <input type="radio"/> No | Multiple Sclerosis | <input type="radio"/> Yes <input type="radio"/> No |
| Restless leg syndrome | <input type="radio"/> Yes <input type="radio"/> No | Alzheimer's disease | <input type="radio"/> Yes <input type="radio"/> No |
| Periodic limb movement disorder | <input type="radio"/> Yes <input type="radio"/> No | Memory loss | <input type="radio"/> Yes <input type="radio"/> No |
| Other sleep disorders _____ | | Parkinson's disease | <input type="radio"/> Yes <input type="radio"/> No |
| Heart disease | <input type="radio"/> Yes <input type="radio"/> No | Huntington's disease | <input type="radio"/> Yes <input type="radio"/> No |
| Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Aneurysm | <input type="radio"/> Yes <input type="radio"/> No |
| High blood pressure | <input type="radio"/> Yes <input type="radio"/> No | Migraine | <input type="radio"/> Yes <input type="radio"/> No |
| Stroke | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis | <input type="radio"/> Yes <input type="radio"/> No |

SLEEP HISTORY

- Choose the description that best fits your satisfaction with sleep (only one choice)
 - **No complaints**
 - Always being sleepy
 - Difficulty sleeping (getting to sleep or staying asleep)
 - Not being able to sleep at times desired
 - Not getting enough sleep
- Choose the description of the mood that best fits you (only one choice)
 - Anxious/Nervous
 - Concerned about problems
 - Content
 - Depressed
 - Overworked
 - Stressed
- If you exercise regularly, put a check next to the typical time during the day that you exercise.
 - Not typically performed
 - Morning (before 12:00 p.m.)
 - Afternoon (between 12:00 p.m. and 6:00 p.m.)
 - Evening (after 6:00 p.m.)
- Choose the best description that fits you concerning your current sleeping arrangements:
 - Sleeps alone
 - Sleep in a bed with a partner/roommate
 - Sleeps in a residence with a partner/roommate but not together, i.e, couch or separate beds
- How many times a night do you typically awaken:
 - 0-1 2-4 5-8 more than 8
- Approximately, how many hours of sleep do you get each night?
 - Less than 3 3-5 6-8 more than 8

- 7. How many hours of sleep would you like to get each night?
 5-6 6-7 7-8 more than 8
- 8. Typically, how many naps do you take each week?
 0-1 2-3 4-5 more than 5
- 9. Typically, how long are your naps in minutes?
 0-10 11-20 21-30 more than 30 minutes

If you even occasionally have any of the following problems, please answer yes:

- | | Comments |
|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 1. Do you have problems with penile erections (impotence)? <i>Males only</i> | <input type="radio"/> Yes <input type="radio"/> No _____ |
| 2. Do you have difficulty falling asleep? | <input type="radio"/> Yes <input type="radio"/> No _____ |
| 3. Is your sleep restless or disturbed? | <input type="radio"/> Yes <input type="radio"/> No _____ |
| 4. Do you experience frequent or prolonged awakenings? | <input type="radio"/> Yes <input type="radio"/> No _____ |
| 5. Do you use alcohol to help you fall asleep? | <input type="radio"/> Yes <input type="radio"/> No _____ |
| 6. Do you awake rested? | <input type="radio"/> Yes <input type="radio"/> No _____ |
| 7. On weekends or days off, do you sleep more than one hour later than your usual wake-up time? | <input type="radio"/> Yes <input type="radio"/> No _____ |
| 8. Do you suffer from extreme daytime sleepiness? | <input type="radio"/> Yes <input type="radio"/> No _____ |
| 9. Do you use any medications, including diet pills, to help you stay awake or alert? | <input type="radio"/> Yes <input type="radio"/> No _____ |
| 10. Do you feel it necessary to consume caffeine products (i.e., coffee, cake, soda, chocolate) to maintain an alert or awake state? | <input type="radio"/> Yes <input type="radio"/> No _____ |
| 11. Do you feel that your ability to properly operate a motor vehicle is being effected by daytime sleepiness? | <input type="radio"/> Yes <input type="radio"/> No _____ |
| 12. Have you ever been in an accident or suffered an injury because you feel asleep? | <input type="radio"/> Yes <input type="radio"/> No _____ |
| 13. Does your sleepiness affect your performance at school or work? | <input type="radio"/> Yes <input type="radio"/> No _____ |
| 14. Are your dreams so real you cannot tell if you are asleep or awake? | <input type="radio"/> Yes <input type="radio"/> No _____ |
| 15. On occasion, do you awaken soon after going asleep or in the morning feeling paralyzed, unable to move, or unable to talk? | <input type="radio"/> Yes <input type="radio"/> No _____ |
| 16. While laughing or suddenly excited, do you suddenly loose muscle control or loose | |

strength in your legs and feel the need to sit down or even collapse?

Yes No _____

17. Do you suffer from irritability or crankiness when you are not rested?

Yes No _____

18. Do you have intense episodes of frightening dreams at the time of falling asleep or waking up?

Yes No _____

PATIENT NAME: _____ DATE: _____

COMMENTS

- | | <input type="radio"/> Yes | <input type="radio"/> No |
|----------------------------------------------------------------------------|---------------------------|--------------------------------|
| 1. Do you snore? | <input type="radio"/> | <input type="radio"/> |
| 2. Do you awake at times feeling as if you are choking or gasping for air? | <input type="radio"/> Yes | <input type="radio"/> No _____ |
| 3. Do you have a nasal obstruction or sinus problem? | <input type="radio"/> Yes | <input type="radio"/> No _____ |
| 4. Has your weight increased over the past few years? | <input type="radio"/> Yes | <input type="radio"/> No _____ |
| 5. Do you have headaches upon awakening? | <input type="radio"/> Yes | <input type="radio"/> No _____ |
| 6. Has anybody ever witnessed you stop breathing while you sleep? | <input type="radio"/> Yes | <input type="radio"/> No _____ |
| 7. Do you typically awaken with a dry mouth? | <input type="radio"/> Yes | <input type="radio"/> No _____ |
| 8. Do you typically awaken with a sore throat? | <input type="radio"/> Yes | <input type="radio"/> No _____ |
| 9. Do you ever wheeze at night? | <input type="radio"/> Yes | <input type="radio"/> No _____ |
| 10. Do you ever cough at night? | <input type="radio"/> Yes | <input type="radio"/> No _____ |

- | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|--------------------------------|
| 1. Do you experience repetitive arm or leg movements while asleep? | <input type="radio"/> Yes | <input type="radio"/> No _____ |
| 2. Do you have leg and/or arm discomfort when going to bed or when sitting still which goes away by moving your legs or walking? Answer NO if your leg discomfort is due to a cramping (charley horse) | <input type="radio"/> Yes | <input type="radio"/> No _____ |
| 3. Do you experience sudden jerky body movements at sleep onset causing the inability to initiate sleep? | <input type="radio"/> Yes | <input type="radio"/> No _____ |
| 4. Do you grind or clench your teeth while asleep? | <input type="radio"/> Yes | <input type="radio"/> No _____ |
| 5. Do you sleep walk? | <input type="radio"/> Yes | <input type="radio"/> No _____ |
| 6. Do you experience episodes of extreme terror or screaming during sleep, yet have little, if any, recall of the event? | <input type="radio"/> Yes | <input type="radio"/> No _____ |
| 7. While asleep, have you ever acted out a dream and injured yourself or a bed partner? | <input type="radio"/> Yes | <input type="radio"/> No _____ |
| 8. Do you have episodes of bed wetting during sleep? | <input type="radio"/> Yes | <input type="radio"/> No _____ |

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of 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 to choose the most appropriate number for each situation:

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

Situations:

- | | |
|-----------------------------------------------------------------|-------|
| Sitting and reading | _____ |
| Sitting inactive in a public place (i.e., a theater or 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 minutes in the traffic _____
Watching t.v. _____

TOTAL: _____