Patient Name_____Date of Birth: _____

**PLEASE USE BLACK INK** **Appointment Date: _____**

**PRIOR TO SCHEDULING:** If required by your insurance, an authorization and/or referral needs to be sent to National Jewish Health Sleep Center. Please have this faxed to 303.270.2109.

Patient Name:_____

Primary Insurance:_____ Date of birth:_____

Please describe the reason for your visit and chief complaint/s:_____

| YES | NO | SLEEP HISTORY |
|---|---|---|
| | | Have you had a previous sleep study? **IF YES, WE NEED ANY PRIOR SLEEP STUDY RECORDS IN ORDER TO PROVIDE ANY NEW TESTING AND CARE OPTIONS.** When?_____Name of facility:_____ |
| | | Do you have a diagnosis of Sleep Apnea? |
| | | Are you on a PAP therapy device? If so, what are your settings?_____ Please **bring your PAP equipment** to each Sleep Clinic appointment including mask and tubing |
| | | Are you on oxygen? If so, how much?_____ |

If you currently receive medical equipment, what is the name of your equipment company?

_____

**How likely are you to doze off or fall asleep in the following situations?**

This refers to your usual way of life in **recent times**. If you have not done some of these things recently, try to estimate how they might have affected you. Use the following scale to rate your chance of dozing in the following situations:

**0 – Never 1 – Slight chance2 – Moderate chance 3 – High chance**

| SITUATIONS | SCORE |
|---|---|
| Sitting and reading | |
| Watching TV | |
| Sitting, inactive, in a public place | |
| As a passenger in a car for an hour without a break | |
| Lying down to rest in the afternoon | |
| Sitting and talking to someone | |
| Sitting quietly after a lunch without alcohol | |
| In a car, while stopped for a few minutes in traffic | |
| **TOTAL SCORE** | |

Reference: Johns MW. A new method for measuring daytime sleepiness: the Epworth sleepiness scale. Sleep. 1991 Dec;14(6):540-5.

**MEDICATIONS/ALLERGIES**

**PLEASE BRING A LIST OF ALL CURRENT MEDICATIONS AND DOSAGES AND ANY DRUG AND MEDICATION ALLERGIES** (Current National Jewish Health patients may skip).

National Jewish Health®
Breathing Science is Life.®

HIPAA Patient Request _CC

Patient Label
MRN: X_____
Appt. CSN: _____

**SLEEP QUESTIONNAIRE**

Patient Name_____

Please list medications you have taken for your sleep problem:_____

_____

| YES | NO | CURRENT SLEEP SYMPTOMS – *PLEASE CHECK ALL THAT APPLY* |
|---|---|---|
| | | Excessive daytime sleepiness |
| | | Drowsy driving |
| | | Have you had a recent accident or near miss due to drowsiness |
| | | Insomnia (difficulty falling asleep or staying asleep) |
| | | Frequent snoring |
| | | Wake up gasping, choking, or feeling short of breath |
| | | Witnessed apneas (breath holding during sleep) |
| | | Excessive sweating during sleep |
| | | Nighttime heartburn |
| | | Headaches upon awakening |
| | | Unpleasant sensations in your legs at night or at bedtime |
| | | Twitching or jerking of your legs during sleep |
| | | Frequent disturbing dreams or nightmares |
| | | Unusual movements or behavior during sleep |
| | | Sleepwalking |
| | | Losing muscle strength when laughing, excited, or angry |
| | | Imagine seeing or hearing things as you fall asleep or wake up |
| | | Feeling unable to move (paralyzed) as you fall asleep or wake up |
| | | Teeth clenching/grinding |

| YES | NO | MEDICAL, NEUROLOGICAL, OR PSYCHIATRIC HISTORY |
|---|---|---|
| | | Hypertension |
| | | Heart Failure |
| | | Abnormal cardiac rhythm |
| | | Heart attack |
| | | Asthma |
| | | Chronic obstructive pulmonary disease |
| | | Reflux |
| | | Diabetes |
| | | Thyroid disorder |
| | | Stroke |
| | | Seizures |
| | | Parkinson's disease |
| | | Dementia |
| | | Head trauma |
| | | Depression |
| | | Anxiety disorder |
| | | Post-traumatic stress disorder |
| | | Attention deficit hyperactivity disorder |
| **YES** | **NO** | **MEDICAL, NEUROLOGICAL, OR PSYCHIATRIC HISTORY – CONT.** |
| | | Internal stimulators |
| | | Pacemaker/Defibrillator |
| | | Dentures |
| | | Oral appliance for sleep apnea |
| | | Have you fallen in the past 3 months or do you feel unsteady when standing? |

Patient Name_____

| YES | NO | SLEEP SURGICAL HISTORY |
|---|---|---|
| | | Tonsillectomy-adenoidectomy |
| | | Nasal surgery |
| | | Sinus surgery |
| | | Palate surgery for sleep apnea |

**DEMOGRAPHIC AND SOCIAL INFORMATION**

Please register for a National Jewish Health patient portal account at **nationaljewish.org**
*This will allow you to receive status updates for PAP therapy orders, request prescription refills, view your schedule, request appointments or cancellations, communicate with your care team and much more.*

Emergency contact name:_____ Phone number:_____

Please check your current marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Sleeping habits: ☐ Sleep alone ☐ With bed partner ☐ With pets ☐ With children (co-sleeping)

Occupation:_____

| *Please indicate yes/no and how much per day:* | YES | NO | How much per day? |
|---|---|---|---|
| Caffeinated coffee | | | |
| Caffeinated tea | | | |
| Caffeinated soda | | | |
| Energy drinks | | | |
| Smoking, chewing tobacco, or e-cigarettes | | | |
| Alcohol | | | |
| Recreational drugs including marijuana | | | |
| Exercise | | | |

| YES | NO | SLEEP SCHEDULE |
|---|---|---|
| | | Do you watch TV, read, or use a computer in bed? |
| | | Do you do shift work or work at night? |
| | | Do you take naps during the day?<br>If so, how long do you nap?_____ What time?_____ |

| | WEEKDAYS | WEEKENDS |
|---|---|---|
| What time do you get into bed at night? | | |
| What time do you try to fall asleep? | | |
| How long does it take to fall asleep? | | |
| What time do you wake up? | | |
| Average number of hours of sleep per night | | |

Number of awakenings per night?_____ What causes these awakenings?_____

How do you feel upon awakening?_____

| YES | NO | FAMILY HISTORY – DO ANY OF YOUR FAMILY MEMBERS HAVE: |
|---|---|---|
| | | Snoring |
| | | Sleep apnea |
| | | Insomnia |
| | | Excessive sleepiness |
| | | Narcolepsy |
| | | Restless legs syndrome |

Parents – living or deceased, medical history:_____

Siblings:_____

Other family history:_____

Patient Name_____

| **REVIEW OF SYSTEMS –** ***PLEASE CHECK ALL THAT HAS OCCURRED OVER THE PAST 12 MONTHS*** | | | |
|---|---|---|---|
| *Constitutional:* | | *Gastrointestinal:* | |
| | Weight gain | | Reflux |
| | Change in appetite | | Heartburn |
| | Weight loss | | Abdominal pain |
| | Fatigue | | Abdominal bloating |
| *Allergy-Immunology:* | | *Genito-urinary:* | |
| | Seasonal allergies | | Bedwetting |
| | Sneezing | | Frequent nighttime urination |
| *Head-eyes:* | | *Endocrine:* | |
| | Headaches | | Cold intolerance |
| | Change in vision | | Heat intolerance |
| *Ears-nose-throat:* | | *Musculoskeletal:* | |
| | Sinus symptoms | | Arthritis |
| | Nasal discharge | | Fibromyalgia |
| | Nasal congestion | | Chronic pain |
| | Nose bleeds | | Muscle weakness |
| | Sore throat | *Neurologic:* | |
| | Hoarseness | | Seizures |
| | Mouth breathing | | Stroke |
| | Ear pain | | Memory problems |
| *Lungs:* | | | Concentration problems |
| | Shortness of breath | *Psychiatric:* | |
| | Frequent coughing | | Depressed mood |
| | Wheezing | | Mild worry |
| | Chest tightness | | Anxiety about health |
| *Heart:* | | | Generalized anxiety |
| | Chest pain | | Claustrophobia |
| | Palpitations | | Post-traumatic stress disorder |
| | Heart failure | *Hematologic-Lymphatic:* | |
| | Leg swelling | | Anemia |
| | Sleep with more than 1 pillow | | Bleeding |
| | Waking up short of breath at night | *Skin:* | |
| | | | Rash |
| | | | Eczema/atopic dermatitis |

National Jewish Health is a fragrance-free, non-smoking facility. Please do not wear perfumes, colognes, aftershave, scented lotions or scented hairspray as these can irritate and increase respiratory symptoms in our patients and care team.

Patient Signature: _____Date/Time: _____