FOR OFFICE USE ONLY

PROVIDER:_____

Sleep Center 303.270.2708
303.270.2109 Fax

Main Campus 1400 Jackson Street
Denver, CO 80206

Highlands Ranch Location 8671 S. Quebec St., Ste 120
Highlands Ranch, CO

****Please print clearly and use black ink****

PRIOR TO SCHEDULING: **Appointment Date:** _____

1. **A referral with a diagnosis of INSOMNIA** from the patient's physician must be sent to National Jewish Health Sleep Center, regardless of insurance.
2. Patient to submit completed questionnaire and attached documents. Fax to 303.270.2109
3. If required by your insurance, an authorization needs to be sent to National Jewish Health Sleep Center. Please have this faxed to 303.270.2109.

DEMOGRAPHICS

Patient name:_____

Phone:_____Home Mobile Work (circle one)

Street address:_____ City/State/Zip:_____

Date of birth:_____Age:_____ Gender: ____M _____F _____Other:_____

Education (years of school):_____ Occupation:_____

Marital status:_____ Years:_____ Number of children:_____

SLEEP HISTORY

Please describe your current sleep problem:_____

_____

_____

How long have you had this problem?_____

What do you feel is the major cause(s) of your sleep problem?_____

_____

Describe any treatments you have had for your sleep problem and how well they have worked: _____

_____

_____

Please describe any childhood sleep problems:_____

_____

List any previous sleep studies you have had (date and name of facility). **PLEASE NOTE, WE NEED A COPY OF ANY PRIOR SLEEP STUDY RECORDS.**

_____

_____

Patient Name:

SLEEP SCHEDULE	ON A GOOD NIGHT	ON A BAD NIGHT
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:		

How do you feel upon awakening?_____

How often do you travel across time zones per month?_____

YES	NO	SLEEP SCHEDULE
		Do you do shift work or work at night?
		Do you take naps during the day? If yes, how many times per week?_____ If so, how long do you nap?_____What time?_____

ACTIVITIES YOU DO IN BED AT NIGHT – *PLEASE CHECK THE MOST APPROPRIATE ANSWER*

ACTIVITY	EVERY NIGHT	2-3 NIGHTS PER WEEK	1 NIGHT PER WEEK	2-3 NIGHTS PER MONTH	LESS THAN MONTHLY	NEVER
Watch TV						
Read						
Radio/Audio						
Eat						
Phone						
Work/study						
Computer						

On a scale of 1 to 10 (see scale below), please rate how much difficulty you have with:

no difficulty some difficulty great difficulty

1 2 3 4 5 6 7 8 9 10

Relaxing your body at bedtime	
"Slowing down" or "turning off" your mind while trying to sleep	

BED PARTNER

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

Please list anything your bed partner does that interferes with your sleep:_____

CURRENT SLEEP SYMPTOMS – *PLEASE CHECK ALL THAT APPLY*

	Excessive daytime sleepiness		Unpleasant sensations in legs at night or at bedtime
	Drowsy driving		Twitching or jerking of your legs during sleep
	Recent accident or near miss due to drowsiness		Frequent disturbing dreams or nightmares
	Insomnia (difficulty falling or staying asleep)		Unusual movements or behavior during sleep
	Frequent snoring		Sleepwalking
	Wake up gasping, choking, or feeling short of breath		Losing muscle strength if laughing, excited, angry
	Witnessed apneas (breath holding during sleep)		Seeing or hearing things as you fall asleep/wake up
	Excessive sweating during sleep		Feeling unable to move as you fall asleep/wake up
	Nighttime heartburn		Teeth clenching/grinding
	Headaches upon awakening	**Other:**	

Patient Name:_____

REVIEW OF SYSTEMS – *OVER THE PAST 12 MONTHS*					
√	**PROBLEM**	√	**PROBLEM**	√	**PROBLEM**
	Arthritis		Asthma		Chronic pain
	Depression		Diabetes		Memory/Concentration Problems
	Emphysema/COPD		Epilepsy		Headaches
	Heartburn/Ulcers		High Blood Pressure		Hallucinations/Delusions
	Kidney Problems		Hiatal Hernia		Childhood Hyperactivity
	Panic Attacks		Nose/Throat Problems		Alcohol/Drug Problems
	Sexual Problems		Anxiety/Nervousness		Loss of Sex Drive
	Stroke		Suicide Attempts		Swelling Ankles
	Thyroid Problems		Cold/Heat Intolerance		Trouble Breathing at Night
	Changes in Hair or Skin	**Other:**			

MEDICATIONS – PRESCRIBED AND OVER THE COUNTER

PLEASE LIST MEDICATIONS YOU ARE TAKING OR HAVE RECENTLY STOPPED TAKING (IN THE PAST 12 MONTHS) (continue on back of page or attach current list if needed)

MEDICATION	DOSAGE AND FREQUENCY (e.g., daily, as needed, etc.)	REASON	CURRENT? (YES/NO)

SLEEP AIDS

Currently, how many times per month do you use medications to help you sleep?_____
Currently, how much alcohol do you use to help you sleep?_____Amount per night_____Times per month

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			

ADDITIONAL MENTAL HEALTH HISTORY

Have you ever been treated by the following?	**Yes/No**	**When and for what**	**Name of facility/provider**
Psychiatrist/psychiatric prescriber			
Psychologist/counselor			

Patient Name:_____

EPWORTH SLEEPINESS SCALE

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 chance 2 – 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	

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

INSOMNIA SEVERITY INDEX
PLEASE RATE THE CURRENT (LAST 2 WEEKS) SEVERITY OF THE FOLLOWING:

PROBLEM	NONE	MILD	MODERATE	SEVERE	VERY
Difficulty falling asleep					
Difficulty staying asleep					
Waking up too early					

PROBLEM	NOT AT ALL	A LITTLE	SOMEWHAT	MUCH	VERY MUCH
How satisfied are you with your current sleep pattern?					
How noticeable to others do you think your sleep problem is in terms of impairing the quality of your life?					
How worried are you about your current sleep problem?					
How much does your sleep problem interfere with your daily functioning (daytime fatigue, mood, ability to function at work/chores, concentration, memory, etc)?					

Patient Signature: _____ **Date/Time:** _____

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

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.