SLEEP APNEA PATIENT HISTORY AND PHYSICAL

Date: __________________ Name: ____

Date of Birth: ______________ Age: ________ Referring Physician: ___________________

Usual Bedtime: ________ How long in minutes does it take you to fall asleep: ____________

Please check the appropriate box for your answers:

Have you ever been diagnosed with obstructive sleep apnea or other sleep disorder?

YES ☐ **NO** ☐

Are you using a CPAP or BiPAP device at least 5 days a week? **YES** ☐ **NO** ☐

Do you snore? **YES** ☐ **NO** ☐

Do people tell you that you quit breathing at night? **YES** ☐ **NO** ☐

How often do you dream? **Rarely, if ever** ☐ **Occasionally** ☐ **Most nights** ☐ **Excessively** ☐

What time do you get out of bed in the morning? ________________

Are you sleepy: **Upon Awakening** ☐ **During the Day** ☐

Have you ever fallen asleep while driving? **YES** ☐ **NO** ☐

Do you have an unusual sensation in your legs or a strong desire to move your legs at bedtime:

YES ☐ **NO** ☐

SOCIAL HISTORY

Are you: **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Separated** ☐

Do you have a history of smoking? **YES** ☐ **NO** ☐

What is your occupation? ____

How much alcohol do you drink? **None** ☐ **Rarely** ☐ **Occasionally** ☐ **Daily** ☐

FAMILY HISTORY

Do any of your blood relatives have a history of a sleep disorder? **YES** ☐ **NO** ☐

If yes, what is it? ____

MEDICATIONS (Please list below)

____

ALLERGIES: ____

MEDICAL HISTORY: ____

____

PHYSICIAN USE ONLY BELOW THIS LINE

_____ I have reviewed above with patient and made corrections as needed. This assessment is my own.

_____ Patient consents to telemedicine via video conference and identifies self by name, date of birth and Mother's maiden name.

_____ I have reviewed the above.

Physician Signature _________________________________ **Date** ________________

SLEEP APNEA PATIENT HISTORY & PHYSICAL

KEY: WA: *Witnessed Apnea* ***DR:*** *Dream Rarely* ***DM:*** *Dream Most Nights*

DE: *Dream Excessively* ***OOB:*** *Out Of Bed* ***SO:*** *Sleep Onset* ***SD:*** *Sleep Driving*

SYD: *Sleepy Driving*