St. Margaret's Health

SMP Health

Patient Name:_____ Age:_____

Phone: _____ DOB:_____

Height:_____ Weight:_____

Occupation:_____

Referring Physician:_____

PATIENT MEDICAL HISTORY

Please circle all that apply.

Diabetes Heart Disease Vein Trouble High Blood Pressure Stroke

Heart Attack Pneumonia Chronic Heart Burn COPD Kidney Disease

Glaucoma Nervous Disorders Bariatric Surgery Seizures (past or present)

Chronic Pain (please describe):_____

Other:_____

Do you use tobacco now? YES NO

If "yes", for how long? _____ Amount daily:_____

Do you feel that you:

Get too little sleep at night?	YES	NO
Get too much sleep at night?	YES	NO
Have trouble getting a good night's sleep?	YES	NO
Have trouble getting to sleep at night?	YES	NO
Have trouble staying asleep at night?	YES	NO
Have trouble getting up in the morning?	YES	NO
Have non-refreshing sleep?	YES	NO
Are sleepy during the day?	YES	NO
Are tired (fatigued) during the day?	YES	NO

What time do you usually go to bed? _____

Does this time vary?_____

Do your work shifts vary? _____

How long does it usually take you to fall asleep?_____

On average, how many hours of sleep do you get each night? _____

When trying to fall asleep, how often do you:	NEVER	SOMETIMES	OFTEN
Have thoughts racing through your mind?	_____	_____	_____
Feel sad or depressed?	_____	_____	_____
Have anxiety/worry about things?	_____	_____	_____
Feel muscle tension?	_____	_____	_____
Feel afraid of not being able to fall asleep?	_____	_____	_____
Feel unable to move?	_____	_____	_____
Have a creeping, crawling, or twitching in your limbs, making you feel you have to move them?	_____	_____	_____
Have any kind of pain or discomfort?	_____	_____	_____
Feel afraid of the dark or anything else?	_____	_____	_____
Feel afraid you won't return to sleep?	_____	_____	_____
Have trouble getting back to sleep?	_____	_____	_____

How many times do you usually awaken each night? _____

On a typical night, what is your longest period of wakefulness?_____

Do you have any problems with:

Nasal congestion?	YES	NO
Swallowing?	YES	NO
A lump or obstruction in your throat?	YES	NO
Do any other members of your family have sleep problems?	YES	NO
Have you ever been unable to sleep for several days at a time?	YES	NO
Do you feel your sleep is abnormal?	YES	NO
Is your performance at work a risk because of fatigue?	YES	NO
Do you get extremely tired while driving?	YES	NO
Do you nap during the day?	YES	NO
If so, how many hours?_____		

Snore loudly?	YES	NO
Hold your breath or stop breathing?	YES	NO
Awaken gasping for air?	YES	NO
Feel your heart pounding?	YES	NO
Sweat a lot while asleep?	YES	NO
Walk in your sleep?	YES	NO
Talk in your sleep?	YES	NO
Fall out of bed?	YES	NO
Grind your teeth?	YES	NO
Remember your dreams?	YES	NO
Wake up from a dream?	YES	NO
Depend on an alarm clock to wake you up?	YES	NO
Have a difficult time waking up?	YES	NO
Wake up with a headache?	YES	NO
Wake up with a dry mouth?	YES	NO

ARE YOU LATEX SENSITIVE? YES NO

Please list any allergies: _____

_____

Sleep Lab

Consent to Video Record Sleep Study

I give my permission to St. Margaret's Health to video record my sleep study for the purpose of use by the facility for my sleep study.

After this use, the video recording will be filed with strict confidential manner, as all other records concerning my care

_____ _____
PATIENT DATE

_____ _____
WITNESS DATE

Medical Record # _____

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