Sleep Wellness Center

get your zzzzzzz

Winmar Diagnostics, Inc.

Patient Name____

Address ____

City/State/Zip____

Phone (H)____________ (W)____________ (C)____________

DOB ______________ Male ☐ Female ☐

Physician ________________Clinic________________

Height (in)________Weight (lbs)________Neck (in)________

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations? Please circle the most appropriate answer.

0=would never doze **1**=slight chance of dozing

2=moderate chance of dozing **3**=high chance of dozing

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting Inactive in a public place	0	1	2	3
As a passenger in a car for an hour with no break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch	0	1	2	3
In a car while stopped in traffic	0	1	2	3

TOTAL=

MEDICAL HISTORY

Have you ever been diagnosed of any of the following?

- ☐ Nasal Obstruction/congestion
- ☐ Nasal Polyps
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Headaches
- ☐ Blackouts
- ☐ Hemophilia (bleeder)
- ☐ Back Trouble
- ☐ Diabetes
- ☐ Asthma
- ☐ Cancer
- ☐ Meningitis
- ☐ Depression
- ☐ Tuberculosis
- ☐ Urine Incontinence
- ☐ Kidney Trouble
- ☐ Heartburn
- ☐ Muscle Cramps
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Thyroid Problems
- ☐ Mental Illness
- ☐ Seizures
- ☐ Bronchitis
- ☐ Fibromyalgia
- ☐ Pneumonia
- ☐ Gout
- ☐ Arthritis
- ☐ Prostate Troubles
- ☐ Fainting

Sleep History

What time do you usually go to bed? ____________________

When do you wake up? ____________________

What time do you get up for the day? ____________________

How many times do you awaken during the night? __________

Do you nap during the day? __________ How often?______

Do you have irregular work hours? ____________________

Have you ever had a sleep study? ____________________

Have you ever been diagnosed with a sleep disorder?________

If yes, please explain: ____________________

Do you use CPAP?__________ What pressure? __________

Do you use supplemental oxygen? ____________________

☐At night only ☐All the time __________LPM

Please check all that apply

- ☐ Snoring
- ☐ Stop breathing or wake up choking/gasping for breath
- ☐ Morning headaches
- ☐ Awaken with sour taste in mouth
- ☐ Falling asleep driving or eating
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Legs jerking during sleep
- ☐ Leg cramps or tingling in legs
- ☐ Weakness or loss of muscle strength with laughing, angry or emotionally upset?
- ☐ Paralysis upon awakening
- Hallucinations while awake
- ☐ Acting out your dreams

Do you smoke? Y N How much? _________

Do you drink any of the following? If so, please state how many on a typical day:

Caffeinated Soda? ________________

Coffee/Tea? ________________

Alcohol? ________________

Surgical History/Medications

Please check past surgeries and list dates

- ☐ Tonsillectomy/Adenoidectomy ________________
- ☐ Nasal Surgery ________________
- ☐ UPPP ________________
- ☐ Heart Surgery ________________
- ☐ Other surgeries (please list) ________________

Medications:________________________________

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