

NEUROLOGY AND SLEEP MEDICINE, P.C.

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BOARD CERTIFIED NEUROLOGY
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Name: _____ Date: _____

Age: _____ Birthdate: _____

Do you have a routine bed-partner: _____

Your primary care doctor: _____

The doctor who sent you: _____

Other doctors whom you see: _____

Please describe your sleep problem or why the doctor sent you:

Most recent occupation: _____

What time do you usually get to bed?

Workdays or weekends? _____ Days off _____

What time do you turn off the lights and try to go to sleep?

Workdays or weekends? _____ Days off _____

How long does it take you to fall asleep? _____ hours _____ minutes

What time do you usually get up in the morning?

Workdays or weekends? _____ Days off _____

How many hours do you sleep at night?

Workdays or weekends _____ Days off _____

How many times do you wake up during the night? _____

How well do you sleep away from home? Worse () Same () Better ()

Have you ever taken prescription or over-the-counter sleeping pills?

Yes () No ()

Do you feel worried, anxious, or nervous about getting a good night's sleep more than two nights per week? Yes () No ()

Do you feel creeping, crawling, or aching feelings your legs?

Yes () No ()

Are you able to keep your legs still while sitting or lying in bed?

Yes () No ()

Do you have leg movements during sleep? Yes () No ()

Do you usually snore? Yes () No ()

When were you first told that you snored? _____ years _____ months

Have you awakened yourself with your own snoring? Yes () No ()

Have you awakened feeling short of breath or with a choking a feeling?

Yes () No ()

Has anyone observed pauses in your breathing while you were sleeping?

Yes () No ()

Do you move about in your sleep? Yes () No ()

Have you ever felt unable to move while falling asleep or waking up?

Yes () No ()

Do you fall asleep or doze when you don't intend to? No ()

If yes, usually how many times per day? _____

How long have you been doing this? _____ years _____ months

Do you take planned naps during the day No ()

If yes, usually how many naps per week? _____

What time do you usually take them? _____

How long have you been doing this? _____ years _____ months

Have you had sleep-talking or sleep-walking? Yes () No ()

Please list other medical problems and surgeries:

Please list all medications you are taking including vitamins:

Do you have allergies to medication? No ()

which medications? _____

Current weight: _____ lbs., your weight 5 years ago _____ lbs.,
your weight 10 years ago _____ lbs.

Do you...			
Smoke cigarettes? _____ packs per day		never	quit _____
Drink caffeinated coffee? _____ oz, per day		never	quit _____
Drink caffeinated soda? _____ oz, per day		never	quit _____
Drink caffeinated tea? _____ oz, per day		never	quit _____
Drink beer? How much? _____		never	quit _____
Drink wine? How much? _____		never	quit _____
Drink liquor? How much? _____		never	quit _____
Use illicit drugs? How much? _____		never	quit _____

Has anyone in your family ever had...

Insomnia	who? _____
Narcolepsy	who? _____
Obstructive sleep apnea	who? _____
Restless legs syndrome	who? _____
Sleepiness during the day	who? _____
Loud snoring	who? _____
Breathing pauses during sleep	who? _____
Sleep-talking or sleep walking	who? _____
Other family medical problems: _____	

Have you had...	
Your tonsils removed?	No ()when _____
Difficulty nose breathing?	No ()since _____
Sinus problems?	No ()since _____
Nasal stuffiness due to allergies?	No ()since _____
High blood pressure?	No ()since _____
Bowel or bladder problems?	No ()since _____
Asthma, emphysema, or bronchitis?	No ()since _____
Heart problems?	No ()since _____
Heartburn or reflux?	No ()since _____
Pains in joints or muscles?	No ()since _____
Serious head injury?	No ()since _____
Frequent headaches?	No ()since _____
Depression?	No ()since _____

The Epworth Sleepiness Scale

Name: _____

Date: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This is an average of how you do feel or would feel if you were doing these things. Please use the most appropriate numbers:

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

<u>Situation</u>	<u>Chance of Dozing</u>
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

THANK YOU, PLEASE BRING THIS PAPER WITH YOU TO YOUR APPOINTMENT.