

William B. Cobb, M.D., P.A.
Ewen Tseng, M.D., P.A.
Keith Matheny, M.D.

SLEEP HISTORY

DATE _____

PATIENT'S NAME _____

Describe your sleep complaint: _____

When and how did it begin? _____

TYPICAL SLEEP HABITS

What time do you usually go to bed? _____

What time do you usually get up? _____

How many hours do you sleep in a typical night? _____

When you awaken in the morning do you feel refreshed? Yes No

When your schedule allows you to sleep as late into the morning as you wish, how many hours do you sleep? _____

Do you nap during the day? Yes No

Do you work a night or rotating shift? Yes No

LEVEL OF SLEEPINESS,

Do you feel you are more sleepy in the day than you should be? Yes No

Do you sometimes doze or fall asleep when you don't intend to? Yes No

Watching TV _____ Reading _____ During conversations _____
At meals _____ At work _____ While driving _____ Other _____

ABILITY TO OBTAIN AND MAINTAIN SLEEP

Do you often have trouble falling asleep? Yes No

Is frequent awakening during the night a problem for you? Yes No

How many times do you awaken during the typical night? _____

Do you awaken several hours early and are unable to go back to sleep? Yes No

BREATHING AND SLEEP

Have you been told that you snore? Yes No

If Yes: When did you first begin to snore? (age) _____

Has your snoring changed since it first began? Yes No

If Yes: How: _____

Rate the loudness of your snoring: Please circle
very soft very loud
1 2 3 4 5 6 7 8 9 10

Is your snoring affected by your sleeping position? Yes No

If Yes: How: _____

Have you been told that you stop breathing or have pauses in your breathing during sleep? Yes No

Does your sleeping position affect your breathing? Yes No

Do you awaken suddenly feeling short of breath or with a choking sensation? Yes No

Do you have trouble breathing through your nose? Yes No
If so, when? _____

GENERAL:

Have you had any of the following surgeries?:
Surgery of Jaws Heart Surgery Tonsillectomy
Pacemaker Implantation Nasal Surgery Uvulopalatopharyngoplasty (UPPP)
Other: _____

Are you allergic to any medicine? Specify: _____

Are you on any present medication? Specify: _____