ALABAMA SLEEP THERAPY

SLEEP APNEA PATIENT HISTORY AND PHYSICAL

Date: _____ Name: _____

Date of Birth: _____ Age: _____ Referring Healthcare Provider:_____

Please check the appropriate box for your answers:

Have you ever been diagnosed with obstructive sleep apnea or other sleep disorder? **YES** ☐ **NO** ☐

Year of sleep study? _____ Diagnosis? _____

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 is your usual bedtime? _____

Do you struggle with insomnia? **YES** ☐ **NO** ☐

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

Are you sleepy: **Upon Awakening? YES** ☐ **NO** ☐ **During the Day? YES** ☐ **NO** ☐

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** ☐

What is your occupation? _____

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

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

Height: _____ **Weight**: _____

FAMILY HISTORY

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

If yes, what is it? _____

MEDICATION ALLERGIES: _____

MEDICATIONS (Please list below)

_____

_____

_____

MEDICAL HISTORY: _____

_____

_____

PHYSICIAN USE ONLY BELOW THIS LINE

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

Physician Signature _____ **Date** _____