NORTH MISSISSIPPI MEDICAL CENTER
PULMONARY CONSULTANTS

Past Sleep History

Name:_____ **DOB:**_____

ON AN AVERAGE NIGHT:

Usual bedtime: _____ **What time do you wake up?** _____

Do you snore? ❑ Yes ❑ No **Has anyone mentioned pauses in your breathing while you sleep?** ❑ Yes ❑ No

How many hours of sleep do you get? _____ **How long does it take you to fall asleep?** _____

How many times do you wake up? _____ **Please list reasons why** _____

Do you have restless / crawling feelings in your legs that cause you to stay awake? ❑ Yes ❑ No

Do you have heartburn at night that keeps you awake? ❑ Yes ❑ No

Do you experience headaches and/or dry mouth on awakening in the morning? ❑ Yes ❑ No

Do you experience excessive daytime sleepiness? ❑ Yes ❑ No

SLEEP HYGIENE:

Do you take naps during the daytime? ❑ Yes ❑ No **If so, how long is each nap?** _____

How many beverages do you drink during the daytime that have caffeine? _____

Do you consider your bed/bedroom comfortable and safe? ❑ Yes ❑ No

Do you exercise regularly? ❑ Yes ❑ No **If so, what time of the day?** _____

What time is your last meal/snack of the day? _____

Do you have a TV or radio on to help you fall asleep? ❑ Yes ❑ No

Do you ever drink alcohol or take sleeping pills to help you sleep? ❑ Yes ❑ No

Is your bed partner causing you to have trouble sleeping? ❑ Yes ❑ No

PATIENT TO COMPLETE

REVIEW OF SYSTEMS

Help us to identify various body systems that have caused you problems in recent months.
Circle any problem you have experienced recently.

Constitutional:	Fever	Night Sweats	Chills	Weight Loss	Fatigue
Eyes:	Blurring	Cataracts	Glaucoma	Blindness	
ENT:	Ringing	Hearing Trouble	Hoarseness	Vertigo	
Mouth:	Bleeding around teeth		Sores	Dentures	
Cardiac:	Chest pain	Pressure in chest	Rapid pulse	Irregular pulse	Heart attack
	Heart Surgery	Pacemaker	Ankle swelling		
Gastrointestinal:	Swallowing trouble	Ulcers	Bleeding	Black stools	Nausea
	Diarrhea	Polyps	Cancer		
Kidney:	Infections	Kidney stones	Bleeding	Prostate	
Musculoskeletal:	Body aches	Stiffness in joints	Swelling in joints	Back pain	Lupus
	Rheumatoid Arthritis	Other Arthritis: _____			
Neurologic:	Seizures	Stroke	Loss of Consciousness		
Endocrine:	Diabetes	Thyroid trouble	Extreme thirst		
Skin:	New rashes	Changing moles	Sores on skin	Skin CA (melanoma)	
Blood:	Anemia	Low blood count	Easy bruising	Leukemia	
Allergic:	Hay fever	Food allergies	Allergy injections		
Emotional:	Nervousness	Depression	Psychosis		
Sleep:	Insomnia	Daytime sleepiness	Nightmares	Waking up choking	Snoring
HIV:	Do you feel that you are at risk for AIDS or HIV? ❑ No ❑ Yes				

REVIEWED WITH THE PATIENT OR PERSON COMPLETING THE FORM:

Physician Signature _____ **Date** _____