Demographics Information

Title: ☐Mr. ☐Ms. ☐Mrs.

Name: _____
First Middle Last

Date of Birth (MM/DD/YYYY)**:** _____ **Gender:** ☐Male ☐Female

Social Security Number: _____

Marital Status
☐Single
☐Married
☐Divorced
☐Legally Separated
☐Widowed

Race
☐American Indian/Alaska Native
☐Asian
☐Native Hawaiian/Other Pacific Islander
☐White
☐Other: _____
☐Decline to Specify

Ethnicity
☐Hispanic or Latino
☐Not Hispanic or Latino
☐Unknown
☐Decline to Specify

Address

Street Address: _____ Apartment/Suite #: _____

Zip: _____ City: _____ State: _____

Contact Information

Home Phone Number: _____ Cell/Other: _____

Email Address (required for Patient Portal access): _____

Emergency Contact

Name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Sleep and Medical History

Please complete this form with as much detail as possible. This information may be used when requesting authorization from your insurance.

- ☐ Acid Reflux
- ☐ Acne
- ☐ ADHD
- ☐ Allergies (add comments)
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Bipolar Disorder
- ☐ Bladder Disease
- ☐ Blood Clots
- ☐ Cancer
- ☐ Central Sleep Apnea
- ☐ Chronic Fatigue
- ☐ Claustrophobia
- ☐ Congestive Heart Failure (enter ejection fraction below)
- ☐ Constipation
- ☐ COPD
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Ear Infections
- ☐ Dry Skin / Eczema
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Erectile Dysfunction
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Hair Loss
- ☐ Hearing Problems
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heartburn
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hormone Imbalance
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Infertility
- ☐ Insomnia
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Memory Loss
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Narcolepsy
- ☐ Obesity
- ☐ Obsessive Compulsive Disorder
- ☐ Obstructive Sleep Apnea
- ☐ Osteoporosis
- ☐ Post-Traumatic Stress Disorder
- ☐ Pulmonary Disease
- ☐ Restless Leg Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Sinus Infections
- ☐ Stomach Ulcers
- ☐ Stroke / TIA
- ☐ Substance Abuse
- ☐ Tuberculosis
- ☐ Ulcerative Colitis

Personal Medical History: Current and Past (Check all that apply)
Comments or Other Medical Conditions not listed above

_____

_____

_____

Surgical History (especially any nose, upper airway, or throat surgeries)

_____

_____

_____

Current Medications (list dose information and dates if possible)

_____

_____

_____

Do you smoke? ☐Never ☐Currently ☐Formerly Quit Date: _____

Years Smoked: _____

Do you drink alcohol? ☐Never ☐Currently ☐Formerly Quit Date: _____

Drinks a Week: _____

Do you use recreational drugs? ☐Never ☐Currently ☐Formerly

What type and how often? _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? (circle the number that best applies)

	No chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (e.g. a theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total Score: _____

In your own words, briefly describe your sleep-related problem(s), including duration, frequency, and severity of symptoms:

_____

_____

_____

Do you, or have you been told that you do, any of the following when you sleep?
(circle the number that best applies)

	Never	Occasionally	3-4 nights a week	Always
Snore Softly / Moderately / Loudly	0	1	2	3
Choke or gasp for breath	0	1	2	3
Have repeated pauses in your breathing	0	1	2	3
Wake up with a headache	0	1	2	3
Wake up for a long period of time	0	1	2	3
Kick or twitch your legs/arms frequently	0	1	2	3
Wake up with an aching discomfort in your legs	0	1	2	3
Need to walk, rub or move your legs for relief	0	1	2	3
Wake up screaming, violent, or confused	0	1	2	3
Act out your nightmares	0	1	2	3
Wake up feeling paralyzed	0	1	2	3
Vivid dreams or nightmares	0	1	2	3
Sleepwalk	0	1	2	3
Grind your teeth	0	1	2	3
Suffer from incontinence (wet the bed)	0	1	2	3
Bite or chew on your tongue	0	1	2	3
Become very rigid or shake violently	0	1	2	3
Fall asleep, even though you feel you are awake	0	1	2	3

During your usual day, do you experience any of the following? (circle the number that best applies)

	Never	Occasionally	3-4 nights a week	Always
Excessive sleepiness	0	1	2	3
Falling asleep when you don't want to	0	1	2	3
When you laugh, or become surprised or angry, do your muscles become weak (jaw dropping, leg buckling, or falling down)	0	1	2	3

Please answer the following questions concerning your normal routine

Which best describes your work/active schedule: ☐9am-5pm ☐3pm-11pm ☐11pm-7am ☐Flexible Schedule ☐Unemployed/Retired

What time do you typically go to bed? Work Days: _____

Non-Work Days: _____

What time do you typically get out of bed? Work Days: _____

Non-Work Days: _____

On average, how long does it take you to fall asleep?

☐ 0-9 minutes ☐ 10-29 minutes ☐ 30-59 minutes ☐ 60+ minutes

If you wake up in the middle of the night, how long does it take you to fall back asleep?

☐ 0-9 minutes ☐ 10-29 minutes ☐ 30-59 minutes ☐ 60+ minutes

Do you take any medications to help you fall asleep? ☐No ☐Yes

What type? _____ How often? _____

Do you think the medicine helps? ☐No ☐Yes

Do you drink beverages that contain caffeine?

☐ Never ☐ Rarely ☐ Sometimes ☐ Very Often ☐ Always

When do you usually drink your last caffeinated beverage before bed?

☐ <1 hour before ☐ 2-6 hours before ☐ 6-10 hours before ☐ >10 hours before

In the last year, have you been in an accident at work or while driving because of your sleepiness?

☐ Never ☐ One time ☐ A few times

How often do you fall asleep while driving?

☐Never ☐Less than once a month ☐Once or twice a month ☐More than twice a month

How frequently do your sleep problems interfere with your daily life? (work, chores, concentration, memory, driving, etc.)

☐Never ☐Rarely ☐Sometimes ☐Very Often ☐Always

How many hours a day do you watch TV and use the computer?

☐<1 hour ☐1-3 hours ☐3-5 hours ☐>5 hours

Do you currently live above 6,500 feet in elevation? ☐No ☐Yes

Have you ever had a sleep study before? ☐No ☐Yes

When? _____ Where? _____

Have you ever been treated for Sleep Apnea? ☐No ☐Yes

Are you currently using PAP therapy? ☐No ☐Yes

What is your current pressure and mask style? _____

Are you currently on oxygen? ☐No ☐Yes

How many liters? _____

Have you ever used an oral appliance (mouth guard, etc.) during sleep to help with your breathing? ☐No ☐Yes

Please provide your most recent measurements for the following:

Weight: _____ Height: _____ Neck Circumference: _____

If applicable, who will be accompanying you for your sleep study? _____

List any other questions or concerns you have:

_____

_____

_____

_____

_____

_____ _____

Patient Signature Date

Please return this completed form as soon as possible. Thank you.

Delta Waves Sleep Disorders and Research Center
5835 Lehman Dr. Suite 101 | Colorado Springs, CO 80918
Phone: (719) 262-9283 | Fax: (719) 262-9285 | www.deltawaves.org