300 B Princeton Hightstown Rd.
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Phone: (609) 490- 1444
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cmdsleep@live.com

CMD
Sleep Disorders Center

Sleep Disorders Health Risk Assessment - Adult

Patient's Name _____
First Middle Last

SLEEP HISTORY

Main Sleep Complaint/Reason for night-time awakenings:

_____

_____

At what age did this problem begin? _____

How does this affect your life and daily activities?

_____

_____

If employed, what are your usual working hours? Start time _____Stop time _____

What time do you usually go to bed and get up on weekdays (or work days)?
_____ to bed _____ get up

What time do you usually go to bed and get up on weekends (or days off)?
_____ to bed _____ get up

Section 1		**Insomnia**
Yes	No	
☐	☐	Do you have trouble falling asleep?
☐	☐	Are you bothered by thoughts that keep you from sleeping?
☐	☐	Are you frightened to go to sleep?
☐	☐	Do you feel depressed or sad?
☐	☐	Does it take you more than a half hour to fall asleep?
☐	☐	Do you awaken much earlier in the morning and are unable to fall back to sleep?

Section 2		**Sleep Apnea**
Yes	No	
☐	☐	Do you often feel that you get too little sleep at night?
☐	☐	Are you bothered by sleepy periods during the day?
☐	☐	Do you remember dreaming?
☐	☐	Do you snore, or has someone told you that you snore?
☐	☐	Does the snoring disturb your bed partner or someone else in the house?
☐	☐	Are you bothered by nightmares?
☐	☐	Are you bothered by breathing problems at night?
☐	☐	Do you have unusual behavior during sleep?
☐	☐	Do you usually feel tired or sleepy during the day?
☐	☐	Do you have high blood pressure?
☐	☐	Have you been gaining weight?
☐	☐	Have you been undergoing changes in your personality?
☐	☐	Do you sweat during the night?
☐	☐	Do you feel you have lost interest in sex?
☐	☐	Do you waken gasping for breath in the middle of the night?
☐	☐	Do you have headaches in the morning?
☐	☐	When you have a cold do you find falling asleep more difficult?
☐	☐	Have you ever felt your heart pounding or beating irregularly during the night?
☐	☐	Have you been told that your performance on the job is not up to par?

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Section 3 **Narcolepsy**

Yes	No	
☐	☐	Do you have difficulty concentrating at school or at work?
☐	☐	Have you fallen asleep at the wheel of a car?
☐	☐	Do you fall asleep during the day?
☐	☐	Have you ever fallen asleep while laughing or crying?
☐	☐	Do your knees get weak if you laugh or get angry?
☐	☐	Have you fallen asleep during physical exertion?
☐	☐	During the day, do you feel dazed as if in a fog?
☐	☐	If you become angry, does your body feel limp?
☐	☐	While falling asleep or awakening, have you experienced vivid dreams?
☐	☐	Soon after falling asleep, have you had nightmares?
☐	☐	Do you often feel that you must fill your day with activity?
☐	☐	No matter how hard you try to stay awake, do you still fall asleep?

Section 4 **GERD**

Yes	No	
☐	☐	Do you gasp for breath during the night?
☐	☐	Do you awaken in the night coughing?
☐	☐	Are you hoarse in the morning?
☐	☐	Do you awaken with heartburn?
☐	☐	Do you have a chronic cough?
☐	☐	Are you taking antacids routinely on a weekly basis?
☐	☐	Do you have frequent sore throats?

Section 5 **Restless Legs/PLMS**

Yes	No	
☐	☐	Do you have pain that interferes with your sleep?
☐	☐	Do you awaken with muscle aches?
☐	☐	Do you have muscle tension in your legs, even outside of exercise?
☐	☐	Do you kick in bed at night?
☐	☐	Even though you sleep at night, do you awaken feeling tired?
☐	☐	Have you experienced a sensation of “crawling” or aching in your legs?
☐	☐	At night, do you feel the need to move your legs?

Does anyone in your family have any sleep problems? Yes _____ No _____

Have you been told or do you have any of the following?

Problem	Yes	Time/Wk.	Age of onset	Last occurred
talk while asleep				
walk while asleep				
grit teeth while asleep				
wake up screaming or afraid for no reason				
stop breathing in your sleep				
awaken with heartburn or sour taste				
other				

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PAST MEDICAL HISTORY

Have you had any of the following:

Surgery	Yes	No	If yes, when?
Tonsillectomy			
Adenoidectomy			
Nasal or sinus surgery			
Vocal cord surgery			
Other surgery			

Any use of prescription or over the counter medications regularly or occasionally?
Yes _____ No _____

If yes, please list by name below:

Name of Medication	Amount	How often	Reason used	How long	Prescribing Doctor

For each of the beverages listed, write the average number you drink per day:

Regular coffee _____ cups/day Decaffeinated coffee _____cups/day

Tea _____ cups/day Caffeinated soft drinks _____cups/day

On the average, how many alcoholic beverages do you drink a week? _____

On the average, how much tobacco do you smoke? (**Please fill in number per day**).

- Cigarettes/day
- Cigars/day
- Pipe/day
- Chewing Tobacco/day

Do you get regular exercise? Yes_____ No _____ how often_____ time of day _____

What kind _____