Augusta Health Sleep Center

221 Medical Center Circle

Fishersville, VA 22939

Phone: 540-332-4169 Fax: 540-332-4168

Sleep Clinic History

1. What is your bedtime? ________________
2. How long does it take you to fall asleep after turning off the lights? ____________________
3. What time do you usually wake up? ___________________
4. How many hours of sleep do you typically get? ________________
5. How many times do you awaken during a typical night? ________________
6. Do you nap during the day? _________________________ For how long? ____________________
7. List any methods you have used to improve your sleep difficulties: _________________________________

____

____

Review of Systems:

Are you currently having problems with the following (Circle Yes (Y) or No (N) as appropriate)

Constitutional

Night Sweats Y N

Recurrent fevers Y N

Weight loss in the past year Y N

Weight gain in the past year Y N

How much? __________

Eyes

Double vision Y N

Vision loss Y N

Glaucoma Y N

Cardiovascular

Chest pain or angina Y N

High blood pressure Y N

Irregular pulse Y N

Heart murmur Y N

Respiratory

Asthma Y N

Chronic cough Y N

Shortness of breath Y N

Gastrointestinal

Indigestion/pain with eating Y N

Liver disease/jaundice Y N

Ulcers/gastritis Y N

Heartburn/reflux Y N

Musculoskeletal

Back pain Y N

Joint pain Y N

Muscle aches Y N

Genitourinary

Recurrent urinary tract infections Y N

Urinary incontinence/accidents Y N

Neurological

Fainting spells/"blacking out" Y N

Seizures Y N

Frequent headaches/migraines Y N

Psychiatric

Anxiety Y N

Depression Y N

Other psychiatric condition Y N

Endocrine

Diabetes Y N

Thyroid disease Y N

Hormone problems Y N

Hematologic/Lymphatic

Anemia Y N

Easy bleeding Y N

Persistent swollen glands/lymph nodes Y N

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What hand do you write with? RIGHT LEFT

Please list your current medical problems:

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______

Please list your prior surgeries:

1. ______
2. ______
3. ______
4. ______
5. ______

Please list your current medications:

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______
11. ______
12. ______

Please list any medication allergies: ______

Do any illnesses run in your family (sleep apnea, cancer, strokes, heart problems, etc.)? ______

What is your marital status? Married Single Widowed Divorced

Occupation: ______

Do you use tobacco? ______ How much? ______

Do you drink alcohol? ______ How much? ______

Are you claustrophobic? ______