Sleep History

Name:_____ DOB: _____

Primary Provider: _____ BMI: _____

Please answer the following questions:	Please circle your response:	
Do you snore?	Yes	No
Do you wake up gasping for air?	Yes	No
Has anyone ever noticed you stop breathing in your sleep?	Yes	No
Do you sleep walk?	Yes	No
Do you "act-out" your dreams?	Yes	No
Do you have restless legs?	Yes	No
Do you use oxygen?	Yes	No
Do you experience a racing heart during sleep?	Yes	No
Do you feel sleepy, tired, a lack of energy, or fatigue during waking hours?	Yes	No

Please circle all that apply to your medical history:

High blood pressure	Neuromuscular disease	Epilepsy	Missing Limbs
Diabetes	Congestive heart failure	Prior stroke	
Chronic lung disease	Other neurologic disease	Dementia	

The Epworth Sleepiness Scale

On a scale of 0 to 3 rank the following with regard to chance for dozing off: (0=no chance, 1=slight, 2=moderate, 3=high)

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	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	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch	0	1	2	3
In a car, while stopped in traffic	0	1	2	3

Total Score: _____

An ESS score of >10 indicates excessive daytime sleepiness

This information is intended to help the patient and physician determine if the patient could be experiencing the symptoms of a sleep disorder.

KEETON CLINIC
SLEEP MEDICINE, ALLERGY & ASTHMA