DEMERA

7045 N. Maple Ave.
Suite 108
Fresno, CA 93720
559 431 0340
559 431 0301 fax
www.DeMeraAllergy.com

Sleep Medical History

Patient Name: _____ DOB: _____ Date: _____

Age: _____ Sex: _____ Ht: _____ Wt: _____ BMI: _____ ESS: _____

Primary Physician: _____ Referring Physician: _____

Reason for Visit: _____

Sleep Study? YES / NO If Yes: HST / OVERNIGHT
When: _____ Where: _____

GENERAL SLEEP QUESTIONS:

Do you have a history of heart attack, stroke, diabetes or high blood pressure? ..... YES / NO

Have you had any surgery to the nose, throat or tongue? ..... YES / NO

Have you been told you snore (observed snoring)? ..... YES / NO

Have you been told you stop breathing (observed apnea)? ..... YES / NO

Are you tired during the day (daytime tiredness)? ..... YES / NO

If you are tired during the day:

Are you tired in the morning? ..... YES / NO

Are you tired in the afternoon? ..... YES / NO

Are you tired in the early evening? ..... YES / NO

Do you fall asleep easily? (i.e., fall asleep too easily, at work or while driving) ..... YES / NO

Do you have trouble falling asleep? Are you often worried you will have trouble falling asleep? ..... YES / NO

Do you dream at night? ..... YES / NO

Do you have trouble awakening? ..... YES / NO

Do you have to keep an alarm? ..... YES / NO

Do you sleep though the alarm? ..... YES / NO

Do you have trouble staying asleep once you fall asleep (frequent awakenings)? ..... YES / NO

Do you use Caffeine/Other means to stay awake? ..... YES / NO
If so, what and how often? _____

Do you use medications/Drugs/Alcohol to get to sleep? ..... YES / NO
If so, what and how often? _____

What time do you go to bed? _____ What time do you wake up? _____ Shift work? YES / NO

Are you on CPAP? ..... YES / NO
If so, how long? _____ *What pressure?* _____

Other/Explain: _____

_____