The REM Center™

A Premier Sleep Assessment Facility
(a division of Braaten Health, LLC)
www.remcenter.com

Patient Sleep History

Name:____ Date:_______________

□Yes □No *Have you ever been told that you snore?*

□Yes □No *Do you often look sad or depressed?*

□Yes □No *Have you been told that you hold your breath while you are sleeping?*

□Yes □No *Do you have trouble concentrating at work or at school?*

□Yes □No *Do you have high blood pressure?*

□Yes □No *Have you fallen asleep while driving?*

□Yes □No *Have you been told by friends and family that you are often grumpy or irritable?*

□Yes □No *Have you experienced vivid dreamlike scenes upon falling asleep or awakening?*

□Yes □No *Do you sweat excessively during the night?*

□Yes □No *Have you fallen asleep in social settings such as the movies or parties?*

□Yes □No *Have you noticed your heart pounding or beating irregularly during the night?*

□Yes □No *Do you have dreams soon after you fall asleep or during naps?*

□Yes □No *Do you get morning headaches?*

□Yes □No *Do you have "sleep attacks" during the day no matter how hard you try to stay awake?*

□Yes □No *Do you suddenly wake up gasping for breath?*

□Yes □No *Have you had episodes of feeling paralyzed during your sleep?*

□Yes □No *Are you overweight?*

□Yes □No *Do you wake up at night with an acid/sour taste in your stomach?*

□Yes □No *Do you seem to be losing your sex drive?*

□Yes □No *Do you wake up at night coughing or wheezing?*

□Yes □No *Do you often feel sleepy and struggle to remain alert?*

□Yes □No *Do you wake up suddenly during the night feeling like you are choking?*

□Yes □No *Do you frequently wake up with a dry mouth or sore throat?*

□Yes □No *Do you experience muscle tension in your legs at times other than when exercising?*

□Yes □No *Do you have difficulty falling asleep?*

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☐Yes ☐No *Have you noticed (or others commented) that parts of your body jerk during sleep?*

☐Yes ☐No *Have you had thoughts racing through your mind preventing you from sleeping?*

☐Yes ☐No *Have you been told that you kick at night?*

☐Yes ☐No *Do you wake up and cannot go back to sleep?*

☐Yes ☐No *Do you experience an aching or crawling sensation in your legs while trying to go to sleep?*

☐Yes ☐No *Do you worry about things and have trouble relaxing?*

☐Yes ☐No *Do you experience leg pain or cramps at night?*

☐Yes ☐No *Do you wake earlier in the morning than you would like?*

☐Yes ☐No *Do you feel like you have to move your legs at night in order for them to feel comfortable?*

☐Yes ☐No *Do you lie awake for half an hour or more before falling asleep?*

☐Yes ☐No *Do you feel sleepy during the day even though you slept through the night?*

☐Yes ☐No *Have you taken any naps today?*

How long have you been experiencing your sleep problems?

____

____

☐Yes ☐No *Have you taken any medications, both prescription and OTC, within the last week? If yes, please list them, when you took them and how long you have been taking them.*

____

____

____

☐Yes ☐No *Have you had any caffeinated and/or alcoholic beverages today?*

Past Medical History - *Please mark all that apply.*

☐*Congestive heart failure*	☐*Chronic Obstructive Pulmonary Disease (COPD)*		☐*Acid Relux*
☐*Heart Attack*	☐*Stroke*	☐*Diabetes*	☐*Migraines*
☐*Fibromyalgia*	☐*Pacemaker*	☐*Seizure Disorder*	☐*Alzheimer's*
☐*Depression/Anxiety*	☐*Parkinson's*	☐*Multiple Sclerosis*	☐*Asthma*
☐*HighCholesterol*	☐*Chronic Pain*	☐*Thyroid*	☐*Arthritis*

Other ____

Do you use any of the following? Please mark all that apply.

☐*Wheelchair*	☐*Walker*	☐*Supplemental Oxygen*
☐*Hearing Aids*	☐*Prosthetic Limb*	*Other*_________________

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Is there family history of the following (Please check all that apply):

	Mother	Father	Sister(s)	Brother(s)	Grandparent(s)
Apnea					
Snoring					
Narcolepsy					
Insomnia					
RLS (Restless Leg Syndrome)					
Other sleep disturbances					

☐*Yes* ☐*No* *I was previously diagnosed with a sleep apnea. Please specifiy:*___________________________

If yes, please indicate the treatment used.

- ☐*Yes* ☐*No* *CPAP or BiPAP or Bilevel (circle applicable if known)*
- ☐*Yes* ☐*No* *Oral appliance*
- ☐*Yes* ☐*No* *Sinus, deviated septum or turbinate reduction*
- ☐*Yes* ☐*No* *Uvulopalatopharyngoplasty*
- ☐*Yes* ☐*No* *Laser or other procedure on uvula*
- ☐*Yes* ☐*No* *Mandibular surgery*
- ☐*Yes* ☐*No* *Tonsillectomy and/or adenoidectomy*

I was previously diagnosed with the following:

- ☐*Yes* ☐*No* *Restless legs syndrome*
- ☐*Yes* ☐*No* *Periodic limb movement*
- ☐*Yes* ☐*No* *Narcolepsy*
- ☐*Yes* ☐*No* *Insomnia*