Somnium DIAGNOSTICS LLC

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(540) 723-0995 (540) 723-0997 fax

Patient Name: _____ **DOB:** _____ **Gender:** **M** **F**

Height: _____ **Weight:** _____

1. Have you ever had a sleep study done before? _____ If Yes, where? _____ and when (date)_____and what where the results_____
2. What is your usual bedtime? _____ How long does it take you to fall asleep? _____
3. How often do you wake up during the night? _____
4. On average, how many hours do you sleep per night? _____
5. Do you take naps? Yes No
6. If yes, when and how long?
   ___ Weekdays _____ minutes ___ Weekends _____ minutes
7. How many caffeinated beverages do you drink daily? _____Alcoholic beverages? _____
8. Do you have trouble waking up? Yes No Do you feel tired during the day? Yes No
9. Do you wake up with: A headache? Yes No Sore throat? Yes No
10. Do you fall asleep during inappropriate times? Yes No
11. Do you dream? Yes No Have nightmares? Yes No
12. Do you snore? Yes No Sleepwalk? Yes No
13. Do you feel you are getting enough sleep at night? Yes No
14. Do you take medications to help you sleep? Yes No
    If yes, what medication? _____
15. Do you wake up choking or gasping for breath? Yes No
16. Do you have "restless legs" at night? Yes No
17. Do you wake up feeling rested and refreshed? Yes No
18. Do you have any family members diagnosed with a sleep disorder? Yes No
    If yes, what disorder? _____
19. Please list any additional issues concerning your sleep:

    _____

    _____

Please complete both sides. Revised 7/15/2010

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Patient Name: _____ **DOB:** _____/_____/_____

Please indicate any of the following conditions that apply to you:

Asthma	Yes	No	Diabetes	Yes	No
Emphysema	Yes	No	Urinary Incontinence	Yes	No
Pacemaker/Defibrillator	Yes	No	Hearing Impairment	Yes	No
COPD	Yes	No	Blindness	Yes	No
Congestive Heart Failure	Yes	No	Mental handicap	Yes	No
Irregular heart rhythm	Yes	No	Paralysis	Yes	No
Edema	Yes	No	Claustrophobia	Yes	No
			Infectious Diseases	Yes	No

Please indicate if you use any of the following:

Wheelchair	Yes	No	Home oxygen	Yes	No
Walker	Yes	No	If Yes: Liter flow at rest _____	sleeping _____	
Cane	Yes	No	Nebulizer	Yes	No
Crutches	Yes	No			

Please answer the following questions:

Do you require assistance walking? Yes No

Are you able to get in and out of bed independently? Yes No

Please list any allergies:

_____

_____

Please list any medications you are currently taking:

_____

_____

_____

_____

Please complete both sides Revised 7/15/2010