FirstHealth
OF THE CAROLINAS

7034.07.15217.07 Sunset Date: 1/2025

Place Patient Label Inside This Box

FirstHealth Moore Regional Hospital: ☐ *Moore* ☐ *Richmond*
FirstHealth Montgomery Memorial Hospital: ☐

Name ______ Age ______ Height ______ Weight ______
Date ______ Referring Physician ______
Reason for sleep study: ______

Do you snore? ☐ Yes ☐ No ☐ Don't know If yes, please answer the following:
- Is it loud? ☐ Yes ☐ No ☐ Don't know
- In which position do you snore? ☐ Back only ☐ All positions
- Is it worse on your back? ☐ Yes ☐ No
- Do you snore if you fall asleep in a chair? ☐ Yes ☐ No
- Does it disturb anyone? ☐ Yes ☐ No

Has anyone ever noticed if you stop breathing while sleeping? ☐ Yes ☐ No ☐ Don't know

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Do you wake up gasping or choking while you sleep? ☐ Yes ☐ No ☐ Don't know

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Do you wake up with either of the following: ☐ Dry mouth ☐ Headache

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Do you feel sleepy during the daytime? ☐ Yes ☐ No If yes, please answer the following:
- If yes, how many days per week?
- When did it start? ______
- Is it worsening? ☐ Yes ☐ No ☐ Don't know

Do you take any daytime naps? ☐ Yes ☐ No If yes, please answer the following:
- How many per week? ______
- How long, on average, do they last? ______
- Are the naps refreshing? ☐ Yes ☐ No ☐ N/A

Have you ever had a close call or accident when driving because of sleepiness? ☐ Yes ☐ No ☐ Don't know

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Tell us about your sleep schedule:

What is your weekday bedtime? ______ Wake up? ______
What is your weekend bedtime? ______ Wake up? ______
How long does it take you to fall asleep? ______ ______
Do you wake up in the middle of the night? ☐ Yes ☐ No
How many times per night? ______
Do you fall asleep again easily? ☐ Yes ☐ No

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Do you ever experience restlessness or discomfort in your legs? ☐ Yes ☐ No If yes, please answer the following:

When? ______

What do you do to relieve it? ______

How often does it occur? ______

Does it interfere with sleep? ☐ Yes ☐ No

Have you ever felt the sudden loss of strength (arms, legs) in response to some emotional experience? ☐ Yes ☐ No

Have you ever felt paralyzed when you first wake up or when you are falling asleep? ☐ Yes ☐ No

Do you ever experience vivid or menacing visions while you are falling asleep or during naps? ☐ Yes ☐ No

Do you walk or talk in your sleep? ☐ Yes ☐ No

Have you ever accidentally urinated in bed? ☐ Yes ☐ No

Do you have nightmares? ☐ Yes ☐ No

Tell us about your daytime schedule:

What is your occupation? ______

Work hours (if applicable) ______

If you don't work, how do you occupy your days? ______

______

What do you do in the evening? ______

______

Marital Status: ☐ S ☐ M ☐ W ☐ D

Who lives in your household: ______

Check if any close family member (parents, brothers, sisters and/or children) have:

☐ Heart problems ☐ Cancer
☐ High Blood Pressure ☐ Heartburn
☐ Diabetes ☐ Sleep Apnea
☐ Other: ______

Do you now or have you ever smoked? ☐ Yes ☐ No

If yes, how many cigarettes per day: ______

Do you drink now or have you ever drunk alcohol? ☐ Yes ☐ No

If yes, how much alcohol per day: ______

Do you drink caffeine?

If yes, how many cups per day: ______

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Sleep History

Are you being treated now or have been treated for any illnesses? ☐ Yes ☐ No If yes, please list them:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

Have you ever had any surgeries? ☐ Yes ☐ No If yes, please list them:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

Check any medical conditions you may have: ☐**NONE**

☐Paralysis (even temporary)	☐Stroke or TIA (mini-stoke)	☐Loss of balance	☐Numbness	☐Seizures
☐Loss of memory	☐Headaches	☐Brain injury	☐Back or neck pain	☐TMJ
☐Arthritis	☐Fibromyalgia	☐Neuropathy	☐Chronic fatigue	☐Joint pain
☐Depression	☐Anxiety/Panic attacks	☐Suicide attempts	☐Bipolar Disorder	☐Schizophrenia
☐OCD	☐ADD/ADHD	☐Alcoholism	☐ Drug Abuse	☐Other Psychiatric
☐CAD(Coronary Artery Disease)	☐Atrial Fibrillation	☐High blood pressure	☐Pacemaker	☐CHF(Congestive Heart Failure)
☐Diabetes	☐Hypothyroid (low)	☐Hyperthyroid (high)	☐Kidney disease	☐Liver disease
☐Cancer	☐Anemia	☐Immune deficiency	☐HIV	☐Hepatitis
☐COPD	☐ Emphysema	☐Pulmonary Hypertension	☐Sleep Apnea	☐GERD/Acid Reflux
☐Parkinson's Disease	☐Internal stimulators			

Men:

☐Prostate problems ☐Night-time urination

Women:

☐Abnormal menstrual cycles ☐Pregnant

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Please list your medications (names, dose or strength, how many times a day). Include over-the-counter medications: ☐**NONE**

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________
11. ______________________________
12. ______________________________
13. ______________________________
14. ______________________________
15. ______________________________

- A locked cabinet is available to store medications

Allergies to medications and reactions:

1. ______________________________
2. ______________________________
3. ______________________________

Patient Signature:______________________________ Date: ____________Time: ____________

Technologist Signature:______________________________ Date: ____________Time: ____________