VIRGINIA HEART
Sleep Center

Patient: _____ Date: ____/____/____

Date of Birth: ____/____/____ Sex: M / F

Height: ____' ____" Weight: _____ lbs / kg Neck Size: _____

| | Yes | No | Comments |
|---|---|---|---|
| Do you have sleep attacks in which you suddenly fall asleep at inappropriate times or places? | ☐ | ☐ | _____ |
| Do you snore? | ☐ | ☐ | _____ |
| Do you stop breathing while you're asleep? | ☐ | ☐ | _____ |
| Are you sleepy during the day? | ☐ | ☐ | _____ |
| Do you wake up with a headache? | ☐ | ☐ | _____ |
| Do you nap during the day? | ☐ | ☐ | _____ |
| Any problems with sleepiness while driving? | ☐ | ☐ | _____ |
| Do your legs move when you sleep? | ☐ | ☐ | _____ |
| Do you act out while dreaming? | ☐ | ☐ | _____ |
| As you fall asleep or wake up, do you feel unable to move? | ☐ | ☐ | _____ |
| As you fall asleep or wake up, do you see things that are not there? | ☐ | ☐ | _____ |
| When you are startled, emotional, excited, or happy do you experience extreme weakness (for example, in your legs) or drop things? | ☐ | ☐ | _____ |
| Have you ever had a prior sleep study? | ☐ | ☐ | _____ |
| If Yes, where? (which location) | | | _____ |
| If Yes, when? | | | _____ |
| Do you wear oxygen when you sleep? | ☐ | ☐ | If Yes, what setting? _____ |
| Do you wear a CPAP/BIPAP? | ☐ | ☐ | If Yes, what setting? _____ |
| Have you ever experienced a heart attack or suffered from congestive heart failure? | ☐ | ☐ | _____ |
| Have you suffered a stroke in the last 3 months? | ☐ | ☐ | _____ |
| Do you currently suffer from COPD or asthma? | ☐ | ☐ | _____ |

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