13000 Harbor Center Drive, #202, Woodbridge, VA, 22192
Tel: 703-955-5355 Fax: 703-955-5348

Patient Name: _________________________________ Date of Birth: ____/_____/_______

Primary Care Physician: ________________________ Referring Physician: ___________________

Height_______________ Weight: ______________ Neck Circumference: _____________

Past Medical History (PMH): YES ( ) NO ( ). If yes, please check all that apply below:

Hypertension	Diabetes	Atrial Fibrillation	Hypertension
Asthma	Congestive Heart Failure	Coronary Artery Disease	Thyroid disease
COPD	TIA/Stroke	GERD	Anemia
Headaches/Migraine	Diabetes	Kidney disease	Parkinson disease
Depression	Anxiety	Bipolar	PTSD
Low testosterone	Seizure disorder	Dementia	Allergic Rhinitis
Fibromyalgia	Claustrophobia	Uses Oxygen	cancer

Other PMH:____

Hospitalizations & Surgeries (PSH): YES ( ) NO ( ). If yes, please list below including date:

____
____

Please list any chronic medical conditions for the following family members:

Mother: ____
Father: ____
Brother/sister: ____

Children:____

Social History (Social Hx): Occupation: ____
Working hours: _________am/pm till _________am/pm # of hours you sit in traffic? ___________

Level of Education (please check those that apply): Grade School High School Vocational College Masters PhD MD/ DDS

Marital status: Please check: (Single) (Married) (Divorced) (Widowed) (Living with Significant Other)

Caffeine & Alcohol consumption: Coffee ____________/day Hot chocolate ___________/day

Soda _____________/day Energy Drinks__________/day Chocolate _____ /day

Tea ______________/day Alcohol (Beer, wine, liquor) ________________________/day

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Tobacco (cigarettes, chewing, cigars): Do you currently smoke? (Yes) (No)

If yes, how many per day? _______________When is your last cigarette at night? ________________

Have you ever smoked? (Yes) (No) If you no longer smoke, when did you quit? _____________

Exercise: Do you exercise routinely? (Yes) (No) If yes please check each type you do: Walking Jogging Running Sports Weight training Other________________________

Are you often too tired to exercise? (Yes) (No) Does most of your exercise come from your job? (Yes) (No).

Allergies (Environmental or Food Allergies): YES ( ) NO ( ). If YES, please list allergies:

____
____

Drug allergies: YES ( ) NO ( ). If YES, please list all drug allergies:

____
____

Please list all medications (prescribed, over the counter and vitamins):

MEDICATION	DOSE	FREQUENCY

Immunization History: ____

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SLEEP QUESTIONNAIRE

SLEEP SYMPTOMS: Check all that apply.

Pauses in breathing	Difficulty falling asleep	Teeth grinding. If YES: Mouth Guard: YES NO	I sometimes feel paralyzed just when I wake up or fall asleep
I have been told I snore	I have racing thoughts that prevent me from falling asleep	Bedwetting	I have experienced loss of muscle tone with laughter, anger or other emotions.
snorting	Difficulty staying sleep	Frequent urination at night	I wake up in the middle of the night confused or disoriented
Wake up choking/gasping for air	Wake up too early most mornings	I eat in my sleep	Night terrors
Wake up with dry mouth	Fatigue/tiredness	nightmares	I act out my dreams
Frequent awakenings	Daytime sleepiness	Hallucinations when going to sleep or waking up from sleep	Night sweats
Morning headaches	Frequent refreshing naps	Sleep talking	I scream in my sleep
Wake up un-refreshed	Frequent unrefreshing naps	Sleep walking	Falling out of bed

Routine Sleeping Habits:

My bedtime: Weekdays: From________ am/pm to ________ am/pm; Weekends: From ______ am/pm to _____am/pm

How long does it take you to fall asleep? ____________min/hours

Does your partner snore? (Yes) (No)

Is your bedroom environment? Dark (Yes) (No) Quiet (Yes) (No) Comfortable temperature (Yes) (No) Do you frequently have children or pets in the bed? (Yes) (No)

When do you sleep better (Check which one best applies to you): Weekdays Weekends Vacation

Do you do any of the following in bed: Watch Television (Yes) (No) Video Games (Yes) (No) Computer (Yes) (No) Cell Phone/ Text (Yes) (No)

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Sleep Apnea Quiz: This is short quiz (STOPBANG quiz) designed to quickly help determine if you are at risk for sleep apnea. Please check all that apply:

- ☐ I have been told that I snore loudly
- ☐ I often feel tired, fatigued or sleepy during the day
- ☐ I have been told that I stop breathing during sleep
- ☐ I take medication for high blood pressure
- ☐ I am overweight
- ☐ I am more than 50 years old
- ☐ My neck circumference if more than 16 inches (40 cm)
- ☐ I am a male

You are at high risk for sleep apnea if you checked 3 or more above.

Restless Legs Syndrome Quiz:

Do you have an urge to move your legs when you are sitting or lying? (Yes) (No)

If YES, are they worse during evening/ night? (Yes) (No)

Are they relieved by movement (stretching, getting-up)? (Yes) (No)

Does a bed partner report kicking/sheets in disarray? (Yes) (No)

SLEEP DISORDER HISTORY:

Respond to all that apply:

SLEEP DISORDER	Date diagnosed	Treatments attempted	Current treatment
Sleep Apnea			
Insomnia			
Narcolepsy			
Idiopathic Hypersomnia			
Restless Leg Syndrome			
REM-Sleep Behavior Disorder			
Sleep Walking			
Shift work disorder			

Previous sleep studies and dates: ____

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EPWORTH SLEEPINESS SCALE

This scale refers to your usual way of life in recent times. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

ACTIVITIES	CHANGES OF DOZING OFF			TOTAL
Sitting and reading	1	2	3	
Watching TV	1	2	3	
Sitting inactive in a public place such as movie theater/meeting	1	2	3	
As a passenger in a car driving for an hour without a break	1	2	3	
Lying down resting in the afternoon when circumstances permit	1	2	3	
Sitting and talking to someone	1	2	3	
Sitting quietly after lunch without use of alcohol	1	2	3	
In a car while stop for a few minutes in traffic	1	2	3	
TOTAL				

We want your visit to be very comfortable. Are there any questions or concerns you have? Please list below if any and do not hesitate to contact us prior to your visit. We look forward to meeting you.

____

____

Sign: ____Date: ________________________