CEDARS-SINAI MEDICAL CENTER
THE PAIN CENTER

SLEEP APNEA EVALUATION

PATIENT I.D.

Date: _____ Arrival Time: _____

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Daytime Phone # _____ Alternate Phone # _____

Primary language: _____ Height: ____ Weight: ____ Dominant Hand: ❑ Right ❑ Left

OTHER / REFERRING DOCTORS: please list the Doctors you would like records sent to

Name of Doctor	Specialty	Phone Number	Fax	Address

UNDERSTANDING YOUR SLEEP APNEA: *(Reason for visit)*

Describe in ***your own words*** the sleep problem(s) you would like help with:

_____

_____

_____

Do you snore?	❑ Yes	❑ No
Do you have insomnia?	❑ Yes	❑ No
Have you been told you stop breathing while you sleep?	❑ Yes	❑ No
Do you awaken gasping for breath?	❑ Yes	❑ No
Do you feel fatigued during the day?	❑ Yes	❑ No
Do you nap during the day?	❑ Yes	❑ No
Do you have morning headaches?	❑ Yes	❑ No
Do you wake up feeling tired?	❑ Yes	❑ No
Do you kick during the night?	❑ Yes	❑ No
Do you have difficulty at work because of sleepiness?	❑ Yes	❑ No
Do you have trouble remembering things or concentrating?	❑ Yes	❑ No
Do you have high blood pressure?	❑ Yes	❑ No
Does your bed partner have a sleep problem?	❑ Yes	❑ No
Do you have jaw pain?	❑ Yes	❑ No
Do you have clicking / noise in your jaw joint?	❑ Yes	❑ No

If yes, please describe your jaw problem: _____

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HISTORY OF YOUR SLEEP APNEA

When did your apnea start? _____

When did you have your sleep study? _____

How many studies have you had? _____

EFFECTS OF YOUR SLEEP: Epworth Sleepiness Scale

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

Insert the appropriate number in the column:

0 = never 1 = slight chance 2 = moderate chance 3 = high chance

Sitting and Reading	
Watching TV	
Sitting, inactive, in a public place (meeting, theater etc.)	
As a passenger in a car without a break	
Lying down to rest in the afternoon as circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total	/ 24

PAST MEDICAL PROBLEMS:

List any medical problems or injuries you have ever had.

Year	Describe	Hospital	Doctor

SURGICAL HISTORY ❑ NONE

Please list surgeries you have had, the date, and where it was performed.

1. _____ Date _____ Location _____
2. _____ Date _____ Location _____
3. _____ Date _____ Location _____

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CURRENT MEDICATIONS

List all medications you are currently taking for medical and pain problems including prescribed, over-the-counter, herbs, vitamins. Do not bring your medicines to the clinic unless you have a question to discuss with the physicians.

Name	Pill Strength	# of times taken per day	Doctor who prescribed	Date started

Pharmacy name, phone, and FAX:

ALLERGIES: ❑ No Known Allergies

Medicine	Reaction	Medicine	Reaction

Previous Doctors

List ALL of the doctors you have seen for your sleep problem

Date	Name	Specialty	Address / Phone / Fax

Previous Treatments

Indicate which of the following treatments you have tried for your sleep problem:

❑ Dental device ❑ CPAP ❑ Surgery ❑ Medication ❑ Other _____

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REVIEW OF SYSTEMS:

Please check if you <u>have</u> **or** <u>had</u> any of the following:

General
- ❑ Weight loss
- ❑ Poor appetite
- ❑ Severe fatigue / low energy
- ❑ Cancer

Hematological
- ❑ Anemia
- ❑ Easy bruising
- ❑ Bleeding disorder
- ❑ Taking blood thinners
- ❑ Blood Transfusion:
  ❑ Yes ❑ No

Reaction:_____

Skin
- ❑ Rash
- ❑ Nail changes
- ❑ Bumps / nodules

Head and Neck
- ❑ Headaches
- ❑ Visual changes
- ❑ Mouth problems
- ❑ Neck pain
- ❑ TMJ problems

Cardiac
- ❑ Exercise limitations
- ❑ Chest pain
- ❑ Irregular heartbeat
- ❑ Heart murmurs
- ❑ High or low blood pressure
- ❑ Circulation problems
- ❑ Ankle swelling

Pulmonary
- ❑ Shortness of breath
- ❑ Cough
- ❑ Asthma or bronchitis
- ❑ Lung disease
- ❑ Sleep apnea
- ❑ Snoring

Endocrine
- ❑ Diabetes
- ❑ Thyroid problems

Gastrointestinal
- ❑ Abdominal Pain
- ❑ Nausea or vomiting
- ❑ Constipation
- ❑ Diarrhea
- ❑ History of ulcers or heartburn

Genitourinary
- ❑ Frequent or hesitant urination
- ❑ Pain with urination
- ❑ Blood in urine
- ❑ Incontinence
- ❑ Sexual dysfunction

Musculoskeletal
- ❑ Arthritis -Type:_____
- ❑ Osteoporosis
- ❑ Muscle pain
- ❑ Muscle wasting
- ❑ Fractures

Neurologic
- ❑ Numbness
- ❑ Weakness
- ❑ Falling
- ❑ Stroke
- ❑ Seizures
- ❑ Memory Loss
- ❑ Loss of balance

Infectious Diseases
(check all that apply)
- ❑ Measles ❑ Mumps
- ❑ Chicken Pox
- ❑ Rheumatic fever
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Other:_____
- ❑ HIV ❑ AIDS
- ❑ Herpes (Oral)
- ❑ Herpes (Genital)
- ❑ Shingles
- ❑ Post-herpatic neuralgia

<u>In the last 5 years:</u>
Received:
Pneumovax: ❑ Yes ❑ No
Flu shot: ❑ Yes ❑ No

Gynecologic
- ❑ Pregnant
- ❑ Post-menopausal:

Last Menstrual Period:_____

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HABITS:

Smoking: ❑ Yes ❑ No ❑ Quit Packs per day: _____ Number of years smoked: _____

Alcohol use: ❑ None ❑ Occasional ❑ Daily How much per week? _____

Are you currently using recreational drugs? ❑ No ❑ Yes: ❑ Amphetamines ❑ Cocaine ❑ Heroin ❑ Marijuana ❑ Other: _____

Do you drink caffeine (coffee, tea, etc.)? How many cups per day? _____

Do you clench your teeth? ❑ Yes ❑ No

Do you grind your teeth? ❑ Yes ❑ No

Do you wear a night guard over your teeth? ❑ Yes ❑ No

EXERCISE:

Do you exercise? ❑ No ❑ Yes, what type? _____

How many days per week do you exercise? _____

How long do you exercise each time (on average)? _____

FAMILY HISTORY: Are you adopted? ❑ Yes ❑ No

Member	Deceased or Living		Age	Medical Problems
Father	❑	❑		
Mother	❑	❑		
Siblings	❑	❑		
	❑	❑		
	❑	❑		
	❑	❑		
Spouse	❑	❑		

SOCIAL HISTORY:

Relationship Status: ❑ Single ❑ Separated ❑ Married ❑ Widowed ❑ Domestic Partner: ❑ Female ❑ Male

With whom do you live? Name: _____ Relationship: _____

Highest level of education completed: ❑ Less than High School ❑ High School ❑ Vocational ❑ Graduate ❑ College ❑ Other: _____

Current or most recent occupation: _____

Status: ❑ Full Time ❑ Part time ❑ Self-employed ❑ Homemaker ❑ Retired ____ years ❑ Unemployed _____ years due to pain ❑ Unemployed ____ years due to _____

Are you happy with your job? ❑ Yes ❑ No

Are you on Disability? ❑ No ❑ Yes, Date Started: _____

Reason for disability: _____

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PSYCHOLOGICAL HISTORY:

Describe your mood: _____

_____

Do you have problems with any of the following:

❑ Concentration ❑ Motivation ❑ Sleep ❑ Appetite ❑ Anxiety
❑ Depression ❑ Self-worth ❑ Homicidal thoughts ❑ Suicidal thoughts

Do you have a history of physical or mental abuse? ❑ Yes ❑ No

Are you currently in therapy? ❑ No ❑ Yes, who do you see? _____ Phone # _____

How often do you see him / her? _____

FINANCIAL INFORMATION:

Do you have any legal action pending related to this pain or any other health problem?

❑ No ❑ Yes, Attorney's name:_____ Phone # _____

Address:_____

HEALTHCARE DECISIONS: *(Check boxes that apply)*

❑ Patient prefers to make own medical decisions.
❑ Medical decisions are made jointly between patient and family.
❑ Patient prefers family members to make the major medical decisions.
❑ Patient has Advance Directives: ❑ Yes* ❑ No
* If Yes, Copy of Directives given to CSMC: ❑ Yes ❑ No

Source of information if other than patient: _____

Signature of person acquiring this information: _____

Signature of patient: _____ Date: _____

Evaluation reviewed by Physician:

Name of Physician (*please print*)	Signature of Physician	ID#	Date Signed

For Clinical Use Only:

AHI _____ Blood Pressure _____/_____
O_2 Saturation _____ Heart Rate _____
O_2 Desaturation _____ Respiratory Rate _____

Name of Nurse (Please Print)	Signature / Title	Date	Time
	RN		