



LexingtonSleepSolutions.com

West Columbia Sleep Lab

109 West Hospital Drive, West Columbia, SC 29169
(803) 791-2683 • FAX: (803) 739-0002

Irmo Sleep Lab

7043 St. Andrews Road, Columbia, SC 29212
(803) 936-7049 • FAX: (803) 781-0823

Northeast Sleep Lab

109 Barton Creek Court, Suite A, Columbia, SC 29229
(803) 509-8268 • FAX: (803) 719-8901



Lexington Medical Center

Patient Sleep History and Physical

Name: _____

Age: _____ Date: _____ Referring Physician: _____

Have you ever had a sleep study?

If so, when? _____ And where? _____

Do you snore? ☐ Yes ☐ No ☐ I don't know ☐ Sometimes

How long ago did it start? _____

Is it worsening? ☐ Yes ☐ No

Has anyone ever noticed if you stop breathing? ☐ Yes ☐ No

Do you gasp or choke while you sleep? ☐ Yes ☐ No

Do you and your bed partner sleep in separate rooms because of your snoring?

☐ Yes ☐ No

Do you suffer from morning headaches? ☐ Yes ☐ No

Do you feel sleepy during the daytime? ☐ Yes ☐ No

Do you get up to go to the bathroom at night? ☐ Yes ☐ No

If so, how many times? _____

Have you gained any weight over the last year? ☐ Yes ☐ No

If so, how much? _____

Do you ever get sleepy driving? ☐ Yes ☐ No

Are there times when you have difficulty concentrating in the afternoon?

☐ Yes ☐ No

Do you suffer from memory problems? ☐ Yes ☐ No ☐ I don't know

Do you get irritable easily? ☐ Yes ☐ No

Do you take any daytime naps? ☐ Yes ☐ No

Do you ever experience restlessness or discomfort in your legs? ☐ Yes ☐ No

Do you move or kick your legs while sleeping? ☐ Yes ☐ No

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

Do you ever have bizarre dreams? ☐ Yes ☐ No

Have you ever lain in bed awake and felt paralyzed?

☐ Yes ☐ No

How likely are you to doze off or fall asleep? Please use the following scale:

0 = would never doze 2 = moderate chance of dozing

1 = slight chance of dozing 3 = high chance of dozing

_____ sitting and reading

_____ watching television

_____ sitting inactive in a public place

_____ while a passenger in a car without a break

_____ laying down to rest in the afternoon when circumstances permit

_____ sitting and talking to someone

_____ sitting quietly after lunch without alcohol

_____ in a car, while stopped in traffic for a few minutes

Epworth score: _____ Date: _____

Tell us about your sleep schedule:

What is your bedtime? _____

What time do you get 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

CONTINUED ON BACK

PAST MEDICAL HISTORY

Are you being treated now or have you ever been treated for the following? Please check or list.

- ☐ Hypertension ☐ GERD ☐ Severe Arthritis ☐ Diabetes
☐ Heart Disease ☐ Fibromyalgia ☐ Asthma/COPD
☐ Lower Back Pain ☐ Other _____

Have you ever had any operations? Any injuries?

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

- ☐ Sleep Apnea ☐ Heartburn ☐ High Blood Pressure
☐ Heart Problems ☐ Diabetes

Are there any other health problems in your family?

SOCIAL HISTORY

Marital Status: ☐ S ☐ M ☐ W ☐ D

With whom do you live? _____

What is your occupation? _____

Do you smoke? ☐ Yes ☐ No

How long? _____ How much? _____

Have you quit? ☐ Yes ☐ No If so, when? _____

Do you drink alcohol? ☐ Yes ☐ No

How long? _____ How much? _____

Have you quit? ☐ Yes ☐ No If so, when? _____

Do you drink caffeinated beverages? ☐ Yes ☐ No

How much? _____

Do you take any medications at bedtime? ☐ Yes ☐ No

If so, what and how much?

REVIEW OF SYMPTOMS (Please circle any symptom you have, so we can find out more about it)

Eye problems	such as double or blurred vision; glaucoma; cataracts
Hearing problems	buzzing or ringing in ears
Allergies; hay fever; Sinus problems	
Blood pressure or heart problems	
Asthma; tuberculosis; emphysema; chronic bronchitis	
Stomach problems	heartburn; indigestion; change in bowel habits
Bloody or tarry stools; jaundice; liver problems; ulcers; gallstones	
Urinary problems	frequency; infections; stones; bladder; bed wetting Men: prostate problems; night-time urination Women: abnormal menstrual periods; could you be pregnant
Joint pains	swelling or redness; arthritis; back pain
Muscle aches or tenderness; gout; arthritis	
Rash, itching or other skin problems	
Women: breast lumps; recent mammogram, pap smear and/or pelvic exam	
Paralysis (even temporary); stroke; numbness; loss of balance	
Seizures; loss of memory; headaches	
Unusual thoughts; nervousness; crying or sadness; depression	
Thyroid disorder; diabetes; excess thirst; excess hunger or urination	
Bleeding; easy bruising; risk factors for HIV; anemia; cancer	