1. Patient Information

Patient Name:

Date of Birth (MM/DD/YYYY):

Today's Date:

Phone Number:

Email Address:

Preferred Contact Method:

2. Reason for Evaluation

Describe your primary sleep concerns, chief complaints, or goals for this evaluation:

3. Previous Sleep Testing & Treatment History

Previous Sleep Testing (Sleep Studies, Home Sleep Tests, etc. — List dates, facilities, results):

Previous Sleep Treatments (CPAP/BiPAP, Oral Appliances, surgeries, Sleep Meds — List details):

4. Typical Sleep Patterns

Bedtime (Weekdays):

Bedtime (Weekends/Off):

Time to Fall Asleep (minutes):

Wake Time (Weekdays):

Wake Time (Weekends/Off):

Nighttime Awakenings (Number):

Total Sleep Time (Hours):

Sleep Quality Rating (1-5 or Excellent/Good/Fair/Poor):

5. Sleep Apnea Screening & Related Symptoms

Please check the appropriate box for each screening question:

Snoring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	YES ☐	NO ☐
Tired: Do you often feel tired, fatigued, or sleepy during the daytime (like falling asleep at the wheel)?	YES ☐	NO ☐
Observed: Has anyone observed you stop breathing or choking/gasping during your sleep?	YES ☐	NO ☐
Pressure: Do you have or are you being treated for high blood pressure?	YES ☐	NO ☐
Body Mass Index: Is your BMI greater than 35 kg/m²?	YES ☐	NO ☐
Age: Are you older than 50 years of age?	YES ☐	NO ☐
Neck: Is your neck circumference greater than 16 inches (40 cm)?	YES ☐	NO ☐
Gender: Are you biologically male?	YES ☐	NO ☐
Gasping/Choking: Do you wake up gasping for air, choking, or struggling to breathe?	YES ☐	NO ☐
Heartburn/Reflux: Do you frequently experience nighttime heartburn, acid reflux, or coughing?	YES ☐	NO ☐
Teeth Grinding: Do you grind or clench your teeth during sleep, or wake with jaw soreness?	YES ☐	NO ☐

6. Past Medical History

Check all conditions you have been formally diagnosed with or treated for:

- ☐ Hypertension (HTN)
- ☐ Type 2 Diabetes
- ☐ Atrial Fibrillation (AFib)
- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Stroke / TIA
- ☐ Anxiety / Panic Attacks
- ☐ Depression / Mood Disorder
- ☐ Insomnia
- ☐ Asthma / COPD
- ☐ Gastroesophageal Reflux
- ☐ Hypothyroidism

List any other medical conditions or surgeries here:

7. Social History

Nicotine/Tobacco Use (Never/Former/Current):

Alcohol Use (Drinks per week):

Caffeine Use (Cups/Drinks per day):

8. Current Medications & Prescriptions

Please list all active medications, dosages, and frequency (including over-the-counter sleep aids):

I certify that the above clinical history information is accurate and complete to the best of my knowledge.

Patient Signature (Sign or Type Name below):

Date: