FAUQUIER HEALTH
Sleep Center

Sleep Lab Patient Demographic Form

Please complete this form to help us provide you with the best care. All information is confidential.

Personal Information

- **Full Name:** (First)_____ (Last) _____
- **Date of Birth (MM/DD/YYYY):** _____
- **Gender:** ☐ Male ☐ Female ☐ Other: _____ Preferred **Pronouns:** ☐ He/Him ☐ She/Her ☐ They/Them
- **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Contact Information

- **Address:** _____
- **City:** _____
- **State:** _____
- **ZIP Code:** _____
- **Phone Number:** _____ ☐ Home ☐ Mobile
- **Email Address:** _____

Emergency Contact

- **Name:** _____
- **Relationship to Patient:** _____
- **Phone Number:** _____
- **Alternate Phone Number:** _____

Insurance Information

- **Primary Insurance Provider:** _____ **SSN:** _____
- **Name of Policy Holder (if different from the patient)** _____ **and, DOB:** _____
- **Policy Number:** _____
- **Group Number:** _____
- **Secondary Insurance Provider (if applicable):** _____
- **Policy Number:** _____

Name of Referring Physician: _____ Primary **Care Physician:** _____

Have you had a previous sleep study? ☐ Yes ☐ No, If yes, where, and when?
_____
_____

Do you use any sleep aids (e.g., CPAP, medication)? ☐ Yes ☐ No

- If yes, then who is your current durable medical equipment provider?
  _____
- How long have you had your current system? _____

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Your Name: _____ Date of Birth: _____

Ordering Physician: _____ Date: _____

EPWORTH SLEEPINESS SCALE

The following questions refer to how **sleepy** you usually feel. In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? (This refers to your usual life in recent times. Even if you have not done some of these things recently, try to recall how they have affected you.)

Use the following scale to choose the most appropriate number for each situation:

0 = No Chance 1 = Slight Chance 2 = Moderate Chance 3 = High Chance

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (i.e., theater)	0	1	2	3
As a car passenger for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

TOTAL SCORE

Normal Range of Sleepiness in Healthy Adults	0-10
Mild Sleepiness	11-14
Moderate Sleepiness	15-17
Severe Sleepiness	18-24

OFFICE USE:

Height: _____ Weight: _____ BP: _____ RR: _____ HR: _____

O2: _____ Temp: _____ Neck Circumference: _____

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Date: _____

Name: _____D.O.B. _____/_____/_____

Referring Physician: _____ Height:_____ Weight:_____
Neck Circumference (if known) _____

SLEEP HISTORY: ***Circle where apply***

1. What time do you go to bed? _____ .
2. What time do you wake in the morning? _____.
3. How long does it take for you to fall asleep? _____.
4. How much sleep do you get in hours each night? _____ .
5. Do you wake up in the middle of the night: Yes No
6. If yes, how often? _____ .
7. Do you snore: Yes No Not sure
8. Has anyone seen you stop breathing while sleeping? Yes No
9. If yes, who? _____ .
10. Have you woken yourself up with: Gasping for air Shortness of breath Snorting
11. Do you have excessive daytime sleepiness? Yes No Sometimes
12. Have you gained or lost weight in the last couple of years? Gained Lost
    How many lbs.: _____
13. Any motor vehicle accidents due to sleepiness? Yes No
14. Any Restless Leg Syndrome that interferes with your sleep? Yes No Sometimes
15. Do you kick your legs during sleep? Yes No Sometimes
16. Do you experience weakness in your legs with a sudden emotional change (like laughter, surprise, anger)? Yes No
17. Do you experience hallucinations while drifting to sleep or waking up? Yes No
18. Do you experience Sleep Paralysis? Yes No

PAST MEDICAL HISTORY (include diagnosis):

_____

_____

_____

_____

Have you ever had a sleep study? Yes No When?
_____

Have you ever been diagnosed with Obstructive sleep apnea? Yes No

If yes, do you use CPAP? Yes No

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Name: _____D.O.B. _____/_____/_____

What Durable Medical Equipment (DME) company do you use? _____

Any problem using CPAP therapy? Yes No

If yes, explain: _____

Have you tried treatments other than CPAP? ___Yes ___No

Examples: Dental Device or ENT Surgery

ALLERGIES TO MEDICATIONS: Yes No

If yes, name the medications: _____

CURRENT MEDICATIONS:

_____
_____
_____
_____
_____

FAMILY HISTORY:

Anyone in the family who has sleep disorder

_____
_____
_____

SOCIAL HISTORY:

Marital Status: Single Married Engaged Divorced Separated Widow

Number of Children: _____

What do you do for a living? _____

Do you drink caffeinated beverages?

Coffee: Yes No How much? _____Oz_____

Tea: Yes No How much? _____

Soda: Yes No How much? _____

Energy Drink: Yes No How much? _____

Do you drink alcohol: Yes No how much?

Type: Beer Wine Vodka Mixed drinks others

What time do you drink alcohol? _____

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Name: _____D.O.B. _____/_____/_____

What is your preferred language? _____

What is your primary language? _____

Do you need an interpreter? _____ Yes _____ No

What is your preferred method of learning:

___ Verbal ___Demonstration ___Written ___ Audio/visual

Vision? (Circle one)

Intact Contacts Glasses for Reading Glasses at all times other

Hearing? (Circle one)

Left ear Intact Hard of Hearing Hearing Aid Deaf Other

Right ear Intact Hard of Hearing Hearing Aid Deaf Other

Do you have any cultural, ethnic, or spiritual concerns regarding your care?

_____

_____ .