

**Dr.N. Ramakrishnan**

AB (Int Med), AB (Crit Care), AB (Sleep Med), MMM, FACP, FCCP, FCCM

Name : \_\_\_\_\_ Date : \_\_\_\_/\_\_\_\_/ \_\_\_\_ Case sheet No. \_\_\_\_\_

Sex : Male Female \_\_\_\_\_ Date of Birth : \_\_\_\_/\_\_\_\_/ \_\_\_\_

Age : \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Referred by – Physician/ Self/Others Pl specify \_\_\_\_\_

If referred, Referring physicians' specialty \_\_\_\_\_

**SLEEP HISTORY**

1. What is the primary reason for seeking medical advice? \_\_\_\_\_

2. What time do you usually go to bed? \_\_\_\_\_

3. How long does it take you to fall asleep? \_\_\_\_\_ minutes

4. While you are either falling asleep or waking up do you experience

Dream like images (Hallucinations)?  Yes  No

Feel paralyzed?  Yes  No

5. Do you have difficulty sleeping during the night?  Yes  No

If yes,

A. How often do you usually wake up at night? \_\_\_\_\_

B. When falling asleep, do you experience “restless legs”  
(a feeling of crawling, aching or inability to keep legs still)?  Yes  No

C. Have you ever been told that while asleep you  
Snore?  Yes  No

Quit breathing?  Yes  No

Thrash about / have excessive leg jerking movements?  Yes  No

Walk?  Yes  No

Grind your teeth?  Yes  No

6. What time do you usually wake up? \_\_\_\_\_

7. When you wake up do you feel  
 refreshed?  Yes  No  
 experience headaches?  Yes  No

8. Do you feel tired during daytime?  Yes  No

9. Do you fall asleep when you are trying not to?  Yes  No

10. Have you faced any road/work related accidents or near misses because you were feeling sleepy?  Yes  No

11. Do you watch television/work with computers till late night?  Yes  No

12. Do you attend/make calls from your mobile, before or during sleep?  Yes  No

13. Do you do any regular exercise?  Yes  No  
 If yes, please state the routine \_\_\_\_\_

Nature of work

- Desk work
- Mental exertion
- Home making
- Shift work
- Physical exertion
- Traveling
- Not employed
- Others, please specify \_\_\_\_\_

14. Have you ever used any of the following?

|                     | No | Yes | Substance                         | Frequency |
|---------------------|----|-----|-----------------------------------|-----------|
| Caffeine            |    |     | Coffee<br>Tea<br>Soda             |           |
| Alcohol, cigarettes |    |     | Alcohol<br>Cigarette              |           |
| Street drugs        |    |     | Marijuana<br>narcotics<br>cocaine |           |

**15. Specify if you ever had the following problems:**

| <b>Disease</b>                | <b>No</b> | <b>Yes</b> | <b>Please explain</b> |
|-------------------------------|-----------|------------|-----------------------|
| Asthma / Chronic Lung Disease |           |            |                       |
| Thyroid Problems              |           |            |                       |
| Seizures / Epilepsy           |           |            |                       |
| Broken Nose                   |           |            |                       |
| Nasal Sinus Problems          |           |            |                       |
| Unusual Dental Problems       |           |            |                       |
| High Blood Pressure           |           |            |                       |
| Heart Disease                 |           |            |                       |
| Stroke                        |           |            |                       |
| Diabetes                      |           |            |                       |
| Depression                    |           |            |                       |
| Psychiatric Treatment         |           |            |                       |
| Gained weight                 |           |            |                       |
| Menstrual Irregularities      |           |            |                       |
| Impotence                     |           |            |                       |

**16. Current Medications (including those used for sleeping)**

| <b>Medication</b>  | <b>Specify</b> |
|--|----------------|
| Prescription (Dose & Frequency)  |                |
| Non-Prescription   |                |
| Oxygen Therapy (how much, continuous/nightly, name of home care company) |                |

17. How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired ?  
Please use the following scale to choose the most appropriate number in each situation.

- 0 = Would Never Doze
- 1 = Slight Chance of Dozing
- 2 = Moderate Change of Dozing
- 3 = High Chance of Dozing

| <b>Situation</b>  | <b>Chance of Dozing</b> |
|---|-------------------------|
| Sitting in a relatively quiet place and reading                           |                         |
| Watching Television   |                         |
| Sitting inactive in a public place (e.g. a classroom, meeting or theater) |                         |
| As a passenger in a car or bus for an hour without a break                |                         |
| Lying down to rest during the day   |                         |
| Sitting and talking to someone  |                         |
| Sitting quietly after lunch   |                         |
| Stopping for a few minutes in the traffic, while driving                  |                         |
| <b>Total (numerical value)</b>  |                         |

Residential address:

Phone:

Mobile

Email id

Official address: