MEDICAL RECORD SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of the Surgeon General

REPORT TITLE
SLEEP HISTORY QUESTIONNAIRE (page 1)

OTSG APPROVED *(Date)*

Name:_____ Active Duty ⊙ Retired ○ Civilian ○ Dependent ○ Rank _____

DOB _____ Male ⊙ Female ○ **MOS** _____

Home Address:

_____

_____

Telephone: (Need current up-to-date numbers)

	Yes	No	
Are you deploying in the next 12 months?	☐	☐	If Yes, (month/yr) _____
Are you retiring in the next 12 months?	☐	☐	If Yes, (month/yr) _____
Are you undergoing an MEB?	☐	☐	If Yes, (month/yr) _____
Are you ETSing?	☐	☐	If Yes, (month/yr) _____
Are you PCSing?	☐	☐	

Home/Cell: _____ Work: _____ Unit Phone#: _____

SLEEP HISTORY:

What problems are you having with your sleep? Check all that apply:

☐Snoring ☐Stop breathing when sleeping ☐Unrefreshing sleep ☐Reprimand for oversleeping

☐Urge to fall asleep in daytime ☐Doze off while driving ☐Doze off when not active ☐Other_____

How long have you been dealing with these issues? _____

Have you had a Prior Sleep Study? ⊙Yes ○No If Yes, when and where?_____

Epworth Sleepiness Scale

How likely are you to doze off/fall asleep in the following situations, in contrast to feeling just 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. Use the following scale to choose the most appropriate number for each situation:

[0-Would never doze off] [1-Slight chance] [2-Moderate] [3-High chance]

Sitting and Reading	
Watching TV	
Sitting, inactive in a public place	
Riding as a passenger in the car for an hour without a break	
Laying down to rest in the afternoon when circumstances allow	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total	0

INSOMNIA: (Insomnia Severity Index)

1. Please rate the current SEVERITY of your insomnia problem(s):

	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep	0	1	2	3	4
Difficulty staying asleep	0	1	2	3	4
Problem waking up too early	0	1	2	3	4

2. How SATISFIED/dissatisfied are you with your current sleep pattern?

Very Satisfied	Moderately Satisfied	Satisfied	Dissatisfied	Very dissatisfied
0	1	2	3	4

3. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g., daytime functioning, ability to function at work/daily chores, concentration, memory, mood, etc.)?

Not at all	A little	Somewhat	Much	Very much
0	1	2	3	4

4. How NOTICEABLE to others do you think your sleeping problem is in terms of impairing the quality of your life?

Not at All	A little	Somewhat	Much	Very much
0	1	2	3	4

5. How WORRIED/distressed are you about your current sleep problem?

Not at All	A little	Somewhat	Much	Very much
0	1	2	3	4

Score: 0

SLEEP SCHEDULE

	Weeknights	Weekends
What time do you go to bed?		
What time do you get up in the morning?		
How many hours of sleep do you get a night?		
How many naps do you take a week? How long do they last?		
How long does it take you to fall asleep?		
Number of times you wake up per night?		
How long does it take you to fall back asleep?		

PATIENT'S IDENTIFICATION (For typed or written entries give: Name,-last, first, middle; DOD; DOB)

NAME: **DOD:** **DATE OF BIRTH:**

MEDICAL RECORD SUPPLEMENTAL MEDICAL DATA

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REPORT TITLE
SLEEP HISTORY QUESTIONNAIRE (page 2)

OTSG APPROVED *(Date)*

REVIEW SYSTEMS: (Check all that apply)

- ☐Weight gain in the past year
- ☐Difficulty breathing through nose
- ☐Wake up with headaches
- ☐Grind / clench teeth when asleep
- ☐Wake with fast heartbeat
- ☐Middle of the night urination
- ☐Wake choking or gasping
- ☐Heartburn that wakes you up
- ☐Pain that disturbs your sleep
- ☐Racing thoughts at night
- ☐Nightmares ☐Irritability
- ☐Difficulty concentrating
- ☐Wake up completely paralyzed
- ☐Attacks with muscle weakness
- ☐Urge to move legs when awake
- ☐Kick or jerk legs while asleep
- ☐Sleepwalk ☐Night sweats

MEDICAL AND SURGICAL HISTORY:

Have you been diagnosed with any of the following?	Yes	No
Depression	☐	☐
Anxiety	☐	☐
Post Traumatic Stress Disorder	☐	☐

FAMILY HISTORY:

Mark any of the following disorders that an immediate family member has been diagnosed with.	
Obstructive Sleep Apnea	☐
Narcolepsy	☐
Restless Leg Syndrome	☐

SOCIAL HISTORY:

	# of drinks(Daily/Wk/Monthly)
Alcohol: How much do you typically drink on a regular basis?	
Caffeine: How much do you typically drink on a regular basis?	
Have you ever or are you currently using any Tobacco products?	

Past Medical History:

_____

_____

Past Surgical History, including the year surgery was performed:

_____

_____

Medications that you are currently taking, including prescriptions and over the counter medication:

_____

_____

Medication allergies:_____

[Providers Only Section]

Treatment Ordered: ☐PSG ☐Split ☐Clinic ☐Other_____

VITALS: BP_____ RR_____ HR_____ SPO2_____ HT_____WT_____ Neck Size:_____ ☐ **Vitals Reviewed**

Physical Exam:

Constitutional: ○ Fatigued appearing ◉ Non Fatigued appearing

Occlusion: ○Overbite ○Underbite ◉Normal

ENT: MP 4◉ 3○ 2○ 1○

Tonsil Size: 4◉ 3○ 2○ 1○

Eyes: ○Not sunken ◉No Conjuctivitis

	Abnormal	Normal	
Neuro:	☐	☐	AAO x 3
Psych:	☐	☐	Memory Grossly Intact
Pulm:	☐	☐	RRR, Unlabored
Integumentory:	☐	☐	No rashes(exposed areas)
Musculoskeletal:	☐	☐	Non - antalgic gait

Findings: _____

Evaluated By: ○April Hurlston ○Matthew Rodgers ○Clinton Young ◉Shelley Knowles ○Hunter Hearn
○Karin Nicholson ○Linda Dixon ○Reanetta Little ○Alaine Taylor ○Sean Shirley

PATIENT'S IDENTIFICATION (For typed or written entries give: Name,-last, first, middle; DOD; DOB)

NAME: **DOD:** **DATE OF BIRTH:**