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Name _____

Age _____

General

What time do you usually go to bed on a weekday? _____ am/pm weekend? _____ am/pm

What time is your usual awakening time on a weekday? _____ am/pm weekend? _____ am/pm

What is the total number of hours of sleep that you usually get at night? _____ hours

How long does it usually take you to fall asleep after getting into bed? _____ hour _____ minutes

Do you wake up during a typical night's sleep? Yes/no If yes why? _____

How long is the average awakening? _____

How many times per night do you usually get up? _____

How many naps do you take on purpose during a usual weekday? _____

When falling asleep at the beginning of the night, do you:

Have thoughts racing through your mind? Yes/No

Feel sad and depressed? Yes/No

Have anxiety? (Worry about things) yes/No

Feel muscular tension? Yes/No

Feel afraid of not being able to get to sleep? Yes/No

Notice that parts of your body startle or jerk? Yes/No

Experience restless legs? (Crawling or aching feeling and inability to keep legs still?) Yes/No

Is your sleep disturbed because of:

Asthma? Yes/No

A persistent cough? Yes/No

Shortness of breath when lying flat in bed? Yes/No

Awakening from sleep because of heartburn? Yes/No

Pain in your neck, back, spine, muscles, joints, arms or legs? Yes/ No

Do You?

Wake up with morning headache? Yes/No

Sleep with someone else in your room? Yes/No

Have restless, disturbed sleep? Yes/No

Disturb the sleep of your partner? Yes/No

Snore in any way? Yes/No

Hold your breath or stop breathing during sleep? Yes/No

Suddenly wake up gasping for breath or unable to breathe? Yes/No

Have a night full of intense, vivid dreams? Yes/No

Have nightmares (frightening dreams?) Yes/No

Try to wake up and are extremely disorientated, confuse, and even violent? Yes/No

Feel unable to move (paralyzed) when first falling asleep or waking up? Yes/No

Wake up with pains (aching, "pins and needles" restlessness in your arms or legs)? Yes/No

Have you had a automobile accident or close call due to sleepiness? Yes/No

Experience vivid dream/like images (hallucinations) while falling asleep,

During a nap or when awakening from a nap? Yes/No

Have you felt unable to move (paralyzed) while falling asleep or waking from a nap? Yes/No

Discover that you have performed a complex act such as driving a car to the Wrong destination and not remember how you did it? Yes/No
 Have a feeling of "weak knees" when you laugh? Yes/No
 Have episodes of sudden muscular weakness (paralysis or inability to move) when laughing, angry or in any other emotional situations? Yes/No

Would you or a significant other feel that you have?

Irritability yes/no
 Poor concentration Yes/no
 Chronic fatigue yes/no

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

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Situation	Chance of dozing			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (i.e., movie theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	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: _____

Questions about your general health:

Past medical history

Asthma	yes/no	Lung disease	yes/no	Thyroid disease	yes/no
HIV/AIDS	yes/no	Heart disease	yes/no	High blood pressure	yes/no
Sickle cell	yes/no	Hepatitis	yes/no	Kidney disease	yes/no
Cancer	yes/no	Diabetes	yes/no	Tuberculosis	yes/no
Anemia	yes/no	Acid reflex	yes/no	Bleeding easily	yes/no

List past major surgeries:

List past hospitalizations:

List all prescription medication:

List any non-prescription medications or natural (herbal) products you may be taking:

Allergies to medication and what is your reaction:

General review of symptoms – Do you presently have any problems in the following areas? If yes, please explain.

Constitutional (fever/chills/weight loss)	yes/no	_____
Eyes (vision/eye pain)	yes/no	_____
Cardiac (heart/blood vessels)	yes/no	_____
Respiratory (lungs/blood vessels)	yes/no	_____
Gastrointestinal (stomach/intestines)	yes/no	_____
Genitourinary (genitals/kidney/bladder)	yes/no	_____
Musculoskeletal (muscles/joints)	yes/no	_____
Endocrine (hormones/glands)	yes/no	_____
Hematologic/Lymphatic (blood/ lymph glands)	yes/no	_____
Integument (skin/breast)	yes/no	_____
Neurological (headaches/nervous system)	yes/no	_____
Allergy/Immunol (seasonal allergies/hay fever)	yes/no	_____
Psychiatric	yes/no	_____

Family History: Any family history of the following condition

Bleeding tendency	yes/no	Anesthesia reaction	yes/no
Hearing loss	yes/no	Cancer	yes/no
Diabetes	yes/no	Heart disease	yes/no

Adult Patients Only:

Do you smoke now? Yes/No How much per day _____

Have you ever smoked regularly in the past? Yes/No Year Quit _____

Have you ever used alcohol regularly in the past? Yes/No

Do you drink caffeine? Yes/No How much per day _____

Do you use any drugs, such as marijuana, Heroin, Cocaine? Yes/No

What is your occupation? _____

What is your marital status? Married Single Divorced Widow

Family referring physician name _____

Please inform the doctor's office of any changes in your medial status.

Signature of patient, Parent or Guardian
Doctor's review

Date

Signature of Doctor

Date