Sleep Questionnaire

Patient's Name:			Referring Dr.:		
Today's Date:	DOB:		Age:	Marital Status: S M W D	Gender:
Occupation:			Phone:		Height:
Current Weight:	Weight 1 year ago:	Weight 5 years ago:	5 yrs ago:	10 yrs ago:	20 yrs ago:

What is your main sleep related problem and duration:

_____
_____
_____
_____
_____

SLEEP SCHEDULE (*please provide the following information and circle the answer where appropriate*)

What time do you go to bed on WEEKDAYS? _____ AM or PM WEEKENDS? _____ AM or PM

What time do you wake up on WEEKDAYS? _____ AM or PM WEEKENDS? _____ AM or PM

Do you **nap**? YES NO

How **often** do you **nap**? _____ times per week

How **long** are the **naps**? _____ minutes

Do you **awaken refreshed**? YES NO

Are you a **shift worker**? YES NO If yes, what times do you work? _____

SNORING/ BREATHING HISTORY (*please circle appropriate answer*)

Do you **snore**? DON'T KNOW SOMETIMES YES NO

Does your **sleep position** affect your **snoring**? YES NO

Have you awakened **choking** or short of **breath**? YES NO

Has anyone noticed that you **stop breathing** while asleep? YES NO

Do you have morning **headaches**? YES NO

Do you awaken more than twice to **urinate** during the night? YES NO

Do you awaken **refreshed** in the morning? YES NO

Do you awaken with an **acid or sour taste** in your mouth? YES NO

Do you have **difficulty** sleeping on your **back**? YES NO

SLEEP HISTORY (*please circle appropriate answer)*

Do you have **difficulty falling asleep**?	YES	NO
Do you have **difficulty staying asleep**?	YES	NO
Do you **wake up too early** and cannot get back to sleep	YES	NO
Do you have thoughts **racing through** you mind that make it difficult to sleep?	YES	NO
Have you fallen **asleep unexpectedly**?	YES	NO
Have you ever fallen **asleep** while **driving drowsy**?	YES	NO
Have you ever had a motor **vehicular crash** due to **drowsy driving**?	YES	NO
Have you experienced **"sleep attacks"** (a sudden irresistible urge to sleep?)	YES	NO
Have you experienced **sudden muscle weakness** in response to emotions?	YES	NO
Have you experienced **an inability to move while falling asleep** or waking up?	YES	NO
Have you experienced **dreamlike images** or sounds while falling asleep or waking up?	YES	NO
Do you **kick or jerk** your arms or legs during sleep?	YES	NO
Have you experienced an **urge to move** your legs accompanied by an **uncomfortable** sensation?	YES	NO
Do you have an urge to move your **legs** that **worsens with rest or inactivity** like lying Down or sitting?	YES	NO
Do you have an urge to move your **legs** that is **relieved by walking or stretching**?	YES	NO
Do you have an urge to move and unpleasant sensation **in legs** that occurs **only at night**?	YES	NO
Do you **talk** in your sleep	YES	NO
Do you have **nightmares**?	YES	NO
Have you ever **acted out** your **dreams**?	YES	NO
Do you **grind** your teeth?	YES	NO

MEDICAL/SURGICAL HISTORY (please circle answer and fill in the blank where appropriate)

Have you ever had a sleep study in the past? YES NO When? _____ Where? _____

Do you use home CPAP or BIPAP? YES NO What pressure setting? _____

Who prescribed? _____

Do you use home oxygen? YES NO What liter/flow setting? _____

Do you have a pacemaker/defibrillator with pacemaker (*circle which one*) YES NO

Have you ever had a tonsillectomy? YES NO

Have you ever had sinus or nasal surgery YES NO

Have you ever broken your nose? YES NO

Have you ever had any type of head injury? YES NO

Have you had surgery to promote weight loss? YES NO When? _____

Please check the appropriate box if you have a history of any of the following health problems.

□ Hypertension	□Acid Reflux (heartburn)	□Dementia
□ Heart Attack	□ Arthritis	□ Memory Problems
□ Congestive Heart Failure	□ Fibromyalgia	□ Claustrophobia
□ Cardiac Arrhythmias	□ Sexual dysfunction/loss of libido	
□ Diabetes	□ Depression	
□ Lung problems/COPD/Asthma	□ Anxiety	
□ Stroke/TIA	□ Seizures	

Other _____

FAMILY HISTORY (*does any member of your family have the following)*

Sleep Apnea? YES NO Relationship _____
Narcolepsy? YES NO Relationship _____
Seizure disorder? YES NO Relationship _____
Depression? YES NO Relationship _____
Hypertension? YES NO Relationship _____
Stroke? YES NO Relationship _____
Heart Disease? YES NO Relationship _____
Psychiatric illness? YES NO Relationship _____
Other Disorder _____ Relationship _____

MEDICATIONS (please list, attach a separate sheet if necessary)

Medication	Dose	# Times/Day	Medication	Dose	# Times/Day

Allergies (*please list)*

_____

REVIEW OF SYSTEMS (*please check where appropriate if you have had any of these symptoms in the last 12 months)*

_____ Frequent headaches
_____ Fainting or passing out
_____ Difficulty understanding instructions
_____ Difficulty giving instructions
_____ Difficulty following instructions
_____ Difficulty planning activities/trips
_____ Sudden loss of vision, strength
_____ Hearing loss or ringing in ears
_____ Nosebleeds
_____ Cough for more than 2 weeks
_____ Coughing up blood
_____ Shortness of breath/wheezing
_____ Swelling in feet or ankles
_____ Chest pain or heaviness
_____ Irregular heartbeat
_____ Difficulty swallowing
_____ Abdominal pain
_____Frequent heartburn
_____ Frequent constipation
_____ Difficulty urinating/incontinence
_____ Blood in urine
_____ Urinating more than 2 times a night
_____ Pain in bones or joints
_____ Unusual bruising or bleeding
_____ Convulsions
_____ Change in wart, mole or skin growth
_____ Weight loss of more then 5-10 lbs
_____ Other describe)_____

SOCIAL HISTORY *(please circle answer and fill in the blank where appropriate)*

What is your occupation? _____ If retired, when? _____

Previous jobs held

_____

Marital status _____

Do you share a bed with someone? YES NO

If the answer is "YES" please have your bed partner fill out the Bed Partner/Parent Observation Questionaire.

Have you smoked in the past? YES NO Pack per day? _____ How long? _____
If you quit, when? _____

Do you drink beer, wine, or liquor? (*circle which one)* YES NO How much? _____ How long?

_____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired. Please circle the most appropriate answer using the following scale

0= Never 1= Occasionally 2= Often 3 = Usually				
How likely are you to doze off or fall asleep while sitting and reading?	0	1	2	3
How likely are you to doze off or fall asleep while watching television?	0	1	2	3
How likely are you to doze off or fall asleep while in a theater or meeting?	0	1	2	3
How likely are you to doze off or fall asleep while traveling as a passenger?	0	1	2	3
How likely are you to doze off or fall asleep while resting in the afternoon?	0	1	2	3
How likely are you to doze off or fall asleep while sitting and talking with someone?	0	1	2	3
How likely are you to doze off or fall asleep while sitting quietly after a meal?	0	1	2	3
How likely are you to doze off or fall asleep while sitting in a car stopped in traffic?	0	1	2	3

Total score out of 24: _____ *(please add)*

Signature:
(Patient/guardian/caretaker) _____ Date _____

Reviewing Technologist _____ Date _____

Reviewing Physician _____ Date _____

MID-WEST CENTER FOR SLEEP DISORDERS
www.mwcsd.com

Sleep Log

Patient's Name:	DOB:	Date:

Please fill this form out the *WEEK PRIOR* to your appointment. Bring this completed form with you to the Midwest Center for Sleep Disorders on your scheduled appointment date.

(MINIMUM OF 2 DAYS IS REQUIRED)

SPECIFY UNDER APPROPRIATE DAY OF THE WEEK TO THE RIGHT.	Example	MON	TUES	WED	THURS	FRI	SAT	SUN
TODAY I WENT TO BED AND TURNED THE LIGHTS OFF AT _____.	**11:15 PM**							
AFTER TURNING THE LIGHTS OFF LAST NIGHT, I FELL ASLEEP IN ____ MINUTES.	**40**							
MY SLEEP LAST NIGHT WAS INTERRUPTED __ TIMES. (SPECIFY # OF NIGHTTIME AWAKENINGS)	**3**							
MY SLEEP LAST NIGHT WAS INTERRUPTED FOR ____ MINUTES. (SPECIFY DURATION OF EACH AWAKENING)	**10 5 5**							
THIS MORNING, I WOKE UP AT _____ AM/PM. (NOTE TIME OF LAST AWAKENING)	**6:15 AM**							
THIS MORNING, I GOT OUT OF BED AT _____ AM/PM (SPECIFY THE TIME)	**6:40 AM**							
TOTAL # OF HOURS OF SLEEP LAST NIGHT.	**6 HRS**							
WHEN I GOT UP THIS MORNING, I FELT _____. (1 = VERY GOOD, 5 = VERY BAD)	**2**							
OVERALL, MY SLEEP LAST NIGHT WAS _____. (1 = VERY RESTLESS, 5 = VERY SOUND)	**3**							
TODAY, I NAPPED FOR _____ HRS. (NOTE THE TIMES OF ALL NAPS)	**2 HRS**							
TODAY, I TOOK ____ MG OF MEDICATION AND/OR ____ OZ OF ALCOHOL AS A SLEEP AID.	**ASPIRIN 500 MG**							

Midwest Center for Sleep Disorders
3937 Patient Care Drive, Suite 102 Lansing, MI 48911 Phone: (517) 887-6733 Fax: (517) 887-6736
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Mid-West Center for Sleep Disorders
Bed Partner/Parent Observation Questionnaire

Name of Patient:_____ Date: ___/___/___

Check any of the following behaviors that you have observed the patient doing while asleep

___ loud snoring
___ light snoring
___ twitching of legs or feet during sleep
___ pause in breathing
___ grinding teeth
___ sleep talking
___ sleepwalking
___ bed wetting
___ sitting up in bed but not awake
___ head rocking or banging
___ kicking with legs during sleep
___ getting out of bed but not awake
___ biting tongue
___ becoming very rigid and/or shaking

How long have you been aware of the sleep behaviors(s) that you checked above?

_____

_____

_____

_____

_____

Describe the behavior checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

_____

_____

_____

_____

_____

_____

_____

If you have heard loud snoring, do you remember pauses in the snoring or occasional loud "snorts"?

_____

_____

_____

_____

_____ _____

Signature of Person Completing this Form Relationship