ADULT SLEEP CONSULT

SLEEP HISTORY QUESTIONNAIRE

(best if completed by patient)

Mid-Michigan Sleep Center
8203 S. Saginaw Street
Grand Blanc, MI 48439
Phone: (810) 953-3600 FAX: (810) 953-9547

Mid-Michigan Sleep Center

AMERICAN ACADEMY OF SLEEP MEDICINE — WAKE — SLEEP — MEMBER CENTER

BACKGROUND INFORMATION **Today's Date:**_____

Name:_____ Age: _____ Birthdate: _____ Sex: _____

Home Phone:_____ Work Phone: _____ Cell: _____

Email: _____ Occupation: _____

Pharmacy of Choice: _____ Shift Work?_____

Your Approximate Height:_____ Weight:_____ Neck Size: _____

Family Doctor: _____ Referring Doctor: _____

Please briefly describe why you were referred or what problem you are having:

_____

-How long have you had this problem? _____Is your problem worsening?_____

MEDICATIONS/INHALERS	Dose	Frequency
May make a separate list		

DRUG ALLERGIES	Reaction

OTHER ALLERGIES	Reaction

SURGICAL HISTORY	Date

GENERAL REVIEW OF SYSTEMS

☐ Weight Change	☐ Fever/Chills	☐ Appetite change
☐ Weakness	☐ Rashes/Itching	☐ Skin changes
☐ Headache	☐ Earaches	☐ Ringing in Ears
☐ Itchy Nose	☐ Blurry Vision	☐ Eye Redness
☐ Dry Mouth	☐ Sinus Pain	☐ Stuffy nose
☐ Hoarseness	☐ Nosebleeds	☐ Dentures
☐ Lumps in neck	☐ Sore mouth	☐ Neck Stiffness
☐ Short of breath	☐ Swollen glands	☐ Wheezing
☐ Heart Palpitations	☐ Chest pain	❑ Chest Tightness
☐ Heat/Cold Intolerance	☐ Difficulty Breath-ing laying down	☐ Wake feeling short of breath
☐ Swelling (edema)	☐ Swallowing problem	☐ Nausea
☐ Diarrhea	☐ Constipation	☐ Heartburn
☐ Leg Cramping	☐ Calf Pain with Walking	☐ Pain with urination
☐ Feeling Depressed	☐ Bruise easily	☐ Jaundice
☐ Dizziness	☐ Numbness/Tingling	☐ Muscle/Joint pain
☐ Sweating	☐ Freq. Urination	☐ Tremor
☐ Nervousness	☐ Memory problems	☐ Hyperactivity
☐ Hernia	☐ Claustrophobia	☐ Seizures
☐	☐	☐
☐	☐	☐
☐	☐	☐

DIAGNOSED MEDICAL CONDITIONS (check off)

☐ HYPERTENSION	☐ THYROID	☐ CANCER
☐ DEPRESSION	☐ SEIZURES	☐ STROKE
☐ FIBROMYALGIA	☐ ARTHRITIS	☐ DIABETES
☐ OBESITY	☐ MIGRAINES	☐ ASTHMA
☐ ARTHRITIS	☐ EMPHYSEMA	☐ ALLERGIES
☐ CONGESTIVE HEART FAILURE	☐ HEART ARRYTHMIAS	☐ HEART ATTACK

MEDICAL CONDITIONS (additional)

ADULT SLEEP HISTORY QUESTIONNAIRE—*continued*

HAVE YOU PREVIOUSLY BEEN DIAGNOSED WITH A SLEEP DISORDER? _____
If yes, when and what disorder?
_____
_____

Have you had a previous Sleep Study?_____
Where & when?
_____

SYMPTOMS RELATED TO SLEEP

Please check if you experience any of the following symptoms when sleeping or trying to sleep.

- ☐ Loud snoring
- ☐ Observed apnea (stop breathing) during sleep
- ☐ Awaken gasping for breath or choking
- ☐ Restless sleep
- ☐ Feels sleepy—hard to wake up in morning
- ☐ Wake for the day feeling unrefreshed or tired
- ☐ Grind teeth at night/ wear mouth-guard?____
- ☐ Frequent urination disrupts sleep
- ☐ Wake feeling nauseous
- ☐ Wake with dry mouth
- ☐ Experience a morning headache
- ☐ Legs or arms jerk during sleep
- ☐ Irresistible urge to move legs or arms
- ☐ Wake due to coughing
- ☐ Fall out of bed while sleeping
- ☐ Mouth Breathing
- ☐ Act out your dreams
- ☐ Sleepwalking, Sleep talking, Sleep Terrors
- ☐ Bedwetting
- ☐ Irritability/Depression
- ☐ Memory impairment/Difficulty concentrating
- ☐ Difficulty falling asleep ☐ racing thoughts
- ☐ Difficulty staying asleep
- ☐ Fatigue ☐ Fallen asleep while driving
- ☐ Sleep regularly in a recliner
- ☐ Difficulty sleeping due to pain
- ☐ Weakness in muscles when laughing, angry, surprised or excited
- ☐ Have vivid dreams upon sleep onset or wake
- ☐ Unable to move at sleep onset or awakening

WHAT MEDICATIONS HAVE YOU TRIED TO

Help You Fall Asleep	Help You Stay Awake

SLEEP HABITS

1) What time do you usually get in bed for sleep? _____AM/PM
2) How long does it take you to fall asleep after you have turned out the lights? _____minutes/hours?
3) How often do you awaken each night?_____
4) Total time spent awake in bed?_____ minutes/hours.
5) Usually wake for the day at _____AM/PM?
6) What time do you get out of bed from sleep?_____ AM/PM
7) Indicate the total number of naps per day _____ length____
8) **Avg** hours of sleep at night on week day____ wkend_____
9) Do you do rotating shift work, or have other work schedule changes? Describe: _____

WEIGHT HISTORY

What do you weigh now?_____
What was your **weight**? **1** year ago_____**5** yrs ago_____
Any changes in collar size? _____

SOCIAL HISTORY

Do you **smoke**? _____ Did you previously smoke?_____
# of years smoking _____ How much per day?_____

Do you drink **alcohol**?_____
How much? _____drinks (per day/week/month)

How many **caffeinated beverages** do you drink daily?_____
Caffeine (coffee, tea, chocolate) in AM?_____
Caffeine after noon?_____ Caffeine all day?_____

Recreational drugs?_____
Participate in **sports** or **regular exercise**?_____
What time of day do you exercise?_____

Please list those you **live with**:_____

FAMILY HISTORY (check all that apply)
Is there a family history of:

	Mother	Father	Brother	Sister	Gparent
APNEA					
SNORING					
INSOMNIA					
RESTLESS LEGS SYNDROME					
Other Sleep DISTURBANCES					