ADULT SLEEP FOLLOW-UP
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 your current problem or reason for visit.

_____

NEW MEDICATIONS/ INHALERS or changes	**Dose**	**Frequency**
May make a separate list		

DRUG ALLERGIES	**Reaction**

OTHER ALLERGIES	**Reaction**

RECENT SURGICAL HISTORY	**Date**
Recent Tonsillectomy & Adenoidectomy ?	

MEDICAL CONDITIONS

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

GENERAL REVIEW OF SYSTEMS

☐	Headache	☐	Heartburn	☐	Weight Change Gain/ Loss_____
☐	Bloating	☐	Dry Mouth	☐	Nasal Congestion
☐	Frequent Awakenings	☐	Shortness of breath	☐	Struggle to Breath
☐	Feel Sleepy	☐	Sinus Pain	☐	Sore nose
☐	Cough	☐	Difficulty concentrating	☐	Hyperactivity
☐	Stops Breathing	☐		☐	Chest Congestion

☐	Trouble Maintaining Sleep ☐ Improved ☐ Worse ☐ Same
☐	Trouble Initiating Sleep ☐ Improved ☐ Worse ☐ Same
☐	Restless Legs/Kicking with legs during sleep ☐ Improved ☐ Worse ☐ Same
☐	Sleep Walking/Terror ☐ Improved ☐ Worse ☐ Same
☐	Snoring ☐ Improved ☐ Worse ☐ Same
☐	Feeling Sleepy ☐ Improved ☐ Worse ☐ Same

☐ Current Smoker ☐ Non-smoker (how much? _____)
☐ Caffeine ☐Morning only ☐ Afternoon ☐ All Day (how much ?____)
☐ Naps ☐Every day ☐Occasional ☐None

_____

_____

_____

_____

NEW MEDICAL CONDITIONS
