McLAREN BAY REGION SLEEP CENTER
SLEEP QUESTIONNAIRE

Please call if you have any questions: (989) 894-3332.

☐ Clinic (doctor office visit) patient please complete the following and bring back with you on your appointment date.

_____

Today's Date: _____/_____/_____ Date of Sleep Testing: _____/_____/_____ Time _____ am pm
Who is filling out this questionnaire? ☐ Self ☐ Other _____

Patient Name: _____ Sex: _____

Date of Birth: _____/_____/_____ Age: _____

Occupation: _____ Usual Work Hours/Days: _____

Referring Physician: _____ Family Physician (PCP): _____

How did you hear about the Ingham Center for Sleep & Alertness? (check all that apply)
☐ Health Fair ☐ Doctor ☐ TV/Radio ☐ Relative ☐ Friend ☐ Internet ☐ Other

Please complete the following questionnaire by filling in the blanks or placing a check in appropriate areas.

My Main Sleep Complaint(s) Is:

_____ trouble sleeping at night For how many months/years? _____
_____ being sleepy all day For how many months/years? _____
_____ snoring For how many months/years? _____
_____ unwanted behaviors during sleep, explain _____
_____ Other, explain _____

Vital Statistics:

Height _____ Weight _____ Neck Size _____ inches
What was your weight one year ago? _____ Five years ago? _____
Maximum weight _____ When? _____

Sleep Pattern	Work Days (Weekdays)	Off Days (Weekends)
Typical bedtime:	_____	_____
Typical amount of time it takes to fall asleep:	_____	_____
Typical number of awakenings per night:	_____	_____

Sleep Pattern (continued)	Work Days (Weekdays)	Off Days (Weekends)
List any activities that you normally do during nighttime awakening(s) (i.e., restroom, eat, watch TV):	_____	_____
Typical amount of time to fall back asleep after an awakening:	_____	_____
Typical wake-up time:	_____	_____
Desired wake-up time:	_____	_____
How do you usually awaken; i.e. alarm clock:	_____	_____
Typical time you get out of bed:	_____	_____
Total amount of sleep per night:	_____	_____
Number of naps per day:	_____	_____
When and how long:	_____	_____

Please check all of the following statements that are true about your sleep:

Sleep Habits

_____ I usually watch TV or read in bed prior to sleep.
_____ I frequently travel across 2 or more time zones.
_____ I drink alcohol prior to bedtime.
_____ I smoke prior to bedtime or when I awaken during the night.
_____ I eat a snack at bedtime.
_____ I eat if I awaken during the night.
_____ I typically awaken to urinate during sleep.
_____ I have trouble falling asleep.
_____ I awaken frequently during the night.
_____ I am unable to return to sleep easily if I awaken during the night.
_____ Thoughts start racing through my mind when I try to fall asleep.
_____ I awaken early in the morning, still tired but unable to return to sleep.
_____ I have nightmares as an adult.
_____ I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep.
_____ I sweat a great deal during sleep.
_____ I cannot sleep on my back.

Breathing

_____ I have been told that I stop breathing while asleep.
_____ I awaken at night choking, smothering or gasping for air.
_____ I have been told that I snore.
_____ I have been told that I snore only when sleeping on my back.
_____ I have been awakened by my own snoring.

Restlessness

_____ I am a restless sleeper.
_____ I kick or jerk my legs and/or arms during sleep.
_____ I experience restlessness, tingling or crawling in my arms or legs.
_____ I experience an inability to keep my legs still prior to falling asleep.
_____ I talk in my sleep as an adult.
_____ I have sleep walked as an adult.
_____ I grind my teeth in my sleep.

Daytime Sleepiness

_____ I take daytime naps.
_____ I have a tendency to fall asleep during the day.
_____ I have experienced lapses in time or blackouts.
_____ I have fallen asleep while driving.
_____ I have had auto accidents as a result of falling asleep while driving.
_____ I fall asleep while watching TV.
_____ I fall asleep during conversations.
_____ I fall asleep in sedentary situations.
_____ I performed poorly in school because of sleepiness.
_____ I have had injuries as the result of sleepiness.
_____ I have experienced sudden muscle weakness in response to emotions, i.e. laughter, anger or surprise.
_____ I have experienced an inability to move while falling asleep or when waking up.
_____ I have experienced hallucinations or dreamlike images or sounds when falling asleep or waking up.
_____ I drink caffeinated beverages during the day; _____ cups/bottles/cans per day.

Habits

Have you ever smoked? ☐ Yes ☐ No

If Yes, please answer these questions:

What?	Amount Per Day	For How Long?	When Did You Quit?
☐ Cigarettes	_____ pack(s)	_____ years	_____
☐ Cigars	_____ cigar(s)	_____ years	_____
☐ Tobacco	_____ pipe(s)	_____ years	_____

Did you ever drink alcohol? ☐ Yes ☐ No

If Yes, please answer these questions:

What?	Frequency	Amount Per Week	When Did You Quit?
☐ Beer	☐ Daily ☐ Weekends ☐ Rarely	____ cans/week	_____
☐ Wine	☐ Daily ☐ Weekends ☐ Rarely	____ glasses/week	_____
☐ Liquor	☐ Daily ☐ Weekends ☐ Rarely	____ shots/week	_____

Have you ever used recreational drugs? ☐ Yes ☐ No

If Yes, which ones? _____ When Did You Quit? _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

_____ sleep alone.
_____ share a bed with someone.
_____ share a bedroom, but have separate beds.

_____ share a dwelling, but have separate bedrooms.

Social History (continued)

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired

_____ my job requires driving a vehicle.
_____ I work with dangerous equipment or substances.
_____ I am a shift worker on rotating shifts.
_____ I am a permanent or long-term shift worker. _____third shift _____second shift
_____ I am currently a student.

Medical History

Current Medications -- ***Use separate sheet if necessary***

Medication	Dose (mg)	#Times/day	Medication	Dose (mg)	#Times/day

☐ Pacemaker ☐ Defibrillator ☐ Oxygen ___ lpm ☐ BiPAP® _____ cmH_2O ☐ CPAP ____ CmH_2O

Allergies (e.g. medications, food, tape, mold, flowers): _____

Past Sleep Evaluation and Treatment Where When

___ I have had a previous sleep disorder evaluation _____
___ I have had previous overnight sleep studies _____
___ I have had daytime nap studies _____
___ I have been prescribed a CPAP or bi-level machine for home use _____
___ I have had surgical treatment for a sleep disorder _____
___ I have previously been prescribed medication for a sleep disorder _____
___ I have been previously treated for a sleep disorder _____
___ I have been prescribed oxygen for home use _____

Past Medical History

_____ Hypertension (high blood pressure)
_____ Heart disease
_____ Diabetes
_____ Stomach or colon problems
_____ Lung problems/COPD/asthma
_____ Reflux
_____ Fibromyalgia
_____ Stroke
_____ TIA (“light stroke”)
_____ Blackouts
_____ Seizures
_____ Back or joint problems (arthritis)
_____ Cancer
_____ Thyroid problems
_____ Hepatitis/jaundice
_____ Hearing impairment
_____ Depression or severe anxiety
_____ Alcoholism
_____ Chemical dependency or abuse

Female

_____ Premenstrual Syndrome
_____ Menopause

Male

_____ Prostate problems
_____ Erectile dysfunction/impotence

List other past medical problems and dates:

_____ _____

_____ _____

Please circle any of the following surgeries you have had:

Cholecystectomy	Hernia	D&C	Tonsillectomy
Heart Surgery	Lung Surgery	Hysterectomy	
Carotid Artery Surgery	C-Section	Appendectomy	

Others not listed: _____

Give the following information for the last four times you have been hospitalized starting with the most recent (do not list normal pregnancies):

	Hospitalization #1	Hospitalization #2	Hospitalization #3	Hospitalization #4
Operation or illness				
Year hospitalized				
Name of hospital				

Check any of the symptoms you have had in the PAST 12 MONTHS:

Yes	No		Yes	No	
☐	☐	Frequent headaches	☐	☐	Frequent heartburn or indigestion
☐	☐	Fainting or passing out	☐	☐	Abdominal pain
☐	☐	Sudden loss of vision, strength, inability to speak	☐	☐	Frequent constipation
☐	☐	Hearing loss or ringing in ear(s)	☐	☐	Frequent diarrhea
☐	☐	Hoarseness for more than 2-4 weeks	☐	☐	Rectal bleeding/black stools
☐	☐	Nosebleeds	☐	☐	Difficulty urinating/incontinence
☐	☐	Cough for more than 2-4 weeks	☐	☐	Blood in urine
☐	☐	Coughing up blood	☐	☐	Urinating more than 2 times per night
☐	☐	Shortness of breath or wheezing	☐	☐	Pain in joints or bones
☐	☐	Swelling in feet or ankles	☐	☐	Unusual bruising or bleeding
☐	☐	Chest pain, chest pressure or heaviness	☐	☐	Convulsions
☐	☐	Irregular heartbeat or sudden fast heartbeat	☐	☐	Change in wart, mole or skin growth
☐	☐	Difficulty swallowing or food “sticking”	☐	☐	Weight loss of more than 5-10 lbs.

Family History

Has an immediate blood relative had any of the following?

Yes	No		Relation	Yes	No		Relation
☐	☐	Cancer	_____	☐	☐	Stroke	_____
☐	☐	Diabetes	_____	☐	☐	Anxiety/Depression	_____
☐	☐	Hypertension	_____	☐	☐	Sleep apnea	_____
☐	☐	Heart disease	_____	☐	☐	Narcolepsy	_____

☐ ☐ Thyroid disease _____ ☐ ☐ Other:_____ _____

☐ ☐ Father alive: Age ___ Died @ age ___ ☐ ☐ Mother alive: Age ___ Died @ age ___

Answer Key: 1 – Not Sure 2 – Never 3 – Sometimes 4 – Often ***Using the above answer key, please circle the number that best applies to your life over the* past 6 months*:***	**Not Sure**	**Never**	**Sometimes**	**Often**
I have trouble getting to sleep	**1**	**2**	**3**	**4**
I wake up often during the night	**1**	**2**	**3**	**4**
At bedtime, thoughts race through my mind	**1**	**2**	**3**	**4**
At bedtime, I feel sad and depressed	**1**	**2**	**3**	**4**
When falling asleep, I feel paralyzed (unable to move)	**1**	**2**	**3**	**4**
When falling asleep, I have "restless legs" (a feeling of crawling, aching, or inability to keep legs still)	**1**	**2**	**3**	**4**
I awake suddenly gasping for breath, unable to breathe	**1**	**2**	**3**	**4**
At night my heart pounds, beats rapidly, or beats irregularly ("palpitations")	**1**	**2**	**3**	**4**
I sweat a great deal at night	**1**	**2**	**3**	**4**
My sleep is disturbed by sadness or depression	**1**	**2**	**3**	**4**
I have a lot of nightmares (frightening dreams)	**1**	**2**	**3**	**4**
I feel unable to move (paralyzed) after a nap	**1**	**2**	**3**	**4**
I have dream-like images (hallucinations) when I awaken in the morning even though I know I am not asleep	**1**	**2**	**3**	**4**
I have slept for several days at a time, or at least I have been overwhelmingly sleepy for that long	**1**	**2**	**3**	**4**
I feel that I have trouble getting to sleep or staying asleep	**1**	**2**	**3**	**4**
Now, I am very sleepy during the day and I struggle to stay awake	**1**	**2**	**3**	**4**
In the past 6 months, I have fallen asleep accidentally in some of these situations: eating a meal, talking on the phone, talking to someone, riding in a bus or car, watching TV, at a theater, reading a book, at a lecture	**1**	**2**	**3**	**4**
I received bad grades in school because I was too sleepy	**1**	**2**	**3**	**4**
I now have trouble doing my job because of sleepiness or fatigue	**1**	**2**	**3**	**4**
I often have to let someone else drive the car because I am too sleepy to do it	**1**	**2**	**3**	**4**
I see dream-like images (hallucinations) either just before or just after a daytime nap, yet I am sure I am awake when they happen	**1**	**2**	**3**	**4**
I am often unable to move (paralyzed) when I am waking up in the morning	**1**	**2**	**3**	**4**
Sometimes I realize I have driven my car to the wrong place, and I can't remember how I did it	**1**	**2**	**3**	**4**
I get "weak knees" when I laugh	**1**	**2**	**3**	**4**
I get sudden muscular weakness (or even a brief period of paralysis, being unable to move) when laughing, angry, or in situations of strong emotion	**1**	**2**	**3**	**4**
I have high blood pressure (or once had it)	**1**	**2**	**3**	**4**
My desire or interest in sex is less than what it used to be	**1**	**2**	**3**	**4**
I am unhappy about loving relationships in my life	**1**	**2**	**3**	**4**
I have considered or attempted suicide	**1**	**2**	**3**	**4**
Someone in my family has been hospitalized for a psychiatric illness or "nervous breakdown"	**1**	**2**	**3**	**4**
I smoke tobacco within two hours before bedtime	**1**	**2**	**3**	**4**

I have problems with my nose blocking up when I am trying to sleep (allergies, infections)	**1**	**2**	**3**	**4**
My snoring or my breathing problem is much worse if I sleep on my back	**1**	**2**	**3**	**4**
My snoring or my breathing problem is much worse if I fall asleep right after drinking alcohol	**1**	**2**	**3**	**4**

Regarding drowsiness rather than just fatigue, enter the number that corresponds to how likely drowsiness is to occur to you in the following situations:

0 = Never occurs **1 = Occasionally occurs (25% of the time or less)**
2 = Often occurs **3 = Usually occurs (75% of the time or more)**

Sitting and Reading _____
Watching TV _____
At a public place, i.e. theater or meeting _____
While a passenger in a car for 1 hour _____
Lying down in the afternoon _____
Sitting and talking to someone _____
Sitting down after lunch _____
While driving a car, stopped at a traffic light _____

Total _____

If necessary could you wear a small mask on your nose or nose and mouth to help your breathing at night (like an oxygen mask for example)? ___ Yes ___ No

If No, explain: _____
_____

Is there anything else you would like to make us aware of?

Chart Check Off Technologist Review_____
Name(print) Initial Date

Study Night Technologist Review _____
Name(print) Initial Date

Physician Review _____
Name(print) Initial Date