

Ingham Center for Sleep and Alertness Sleep Questionnaire

Please complete and **mail back immediately** with the yellow form in the envelope provided. If you have any questions please call (517) 377-8525

Name _____ Date of Birth _____ Age ____ Sex _____

Height ____in Weight ____lbs Weight 1 year ago ____lbs Weight 5 years ago ____lbs

SLEEP SCHEDULE *(Please provide the following information, circle 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 kind of shift do you work? _____

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

Previous jobs held _____

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

Do you snore ?	Do Not 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 often 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 your mind that make it difficult to sleep?	Yes	No
Have you fallen asleep unexpectedly ?	Yes	No
Have you ever fallen asleep while 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
Do you have a creepy, crawly sensation in your legs when lying down?	Yes	No
Do you have leg cramps (Charley horse)?	Yes	No
Do you grind your teeth?	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
Have you ever bitten your tongue while sleeping?	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? _____
- Do you use home **oxygen**? YES NO What liter/flow setting? _____
- Do you have a **pacemaker**? YES NO pacemaker or pacemaker/defibrillator
- 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 to the following health problem.

- | | |
|---|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Cardiac Arrhythmias | <input type="checkbox"/> Sexual dysfunction/ loss of libido |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression, Anxiety |
| <input type="checkbox"/> Lung problems/ COPD/Asthma | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Stroke/ TIA | <input type="checkbox"/> Other _____ |

Family History Does any member of your family have the following?

- Sleep Apnea? YES NO Relationship _____
- Narcolepsy? YES NO Relationship _____

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

Do you have any **physical limitations** we should be aware of?

Signature:

(Patient/guardian/caretaker) _____ Date

Reviewing Technologist: _____ Date

Reviewing Physician: _____ Date