

**BAY REGIONAL SLEEP DISORDERS 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**

	<u>Work Days (Weekdays)</u>	<u>Off Days (Weekends)</u>
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

<i>If Yes, please answer these questions:</i>	<u>What?</u>	<u>Amount Per Day</u>	<u>For How Long?</u>	<u>When Did You Quit?</u>
<input type="checkbox"/> Cigarettes		_____ pack(s)	_____ years	_____
<input type="checkbox"/> Cigars		_____ cigar(s)	_____ years	_____
<input type="checkbox"/> Tobacco		_____ pipe(s)	_____ years	_____

Did you ever drink alcohol?  Yes  No

<i>If Yes, please answer these questions:</i>	<u>What?</u>	<u>Frequency</u>	<u>Amount Per Week</u>	<u>When Did You Quit?</u>
<input type="checkbox"/> Beer		<input type="checkbox"/> Daily <input type="checkbox"/> Weekends <input type="checkbox"/> Rarely	_____ cans/week	_____
<input type="checkbox"/> Wine		<input type="checkbox"/> Daily <input type="checkbox"/> Weekends <input type="checkbox"/> Rarely	_____ glasses/week	_____
<input type="checkbox"/> Liquor		<input type="checkbox"/> Daily <input type="checkbox"/> Weekends <input type="checkbox"/> 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**

<u>Medication</u>	<u>Dose (mg)</u>	<u>#Times/day</u>	<u>Medication</u>	<u>Dose (mg)</u>	<u>#Times/day</u>
_____			_____		
_____			_____		
_____			_____		

Pacemaker     Defibrillator     Oxygen \_\_\_\_ lpm     BiPAP® \_\_\_\_\_ cmH<sub>2</sub>O     CPAP \_\_\_\_ CmH<sub>2</sub>O

**Allergies (e.g. medications, food, tape, mold, flowers):** \_\_\_\_\_

**Past Sleep Evaluation and Treatment**

	<u>Where</u>	<u>When</u>
___ 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) | _____ Thyroid problems               |
| _____ Heart disease                      | _____ Hepatitis/jaundice             |
| _____ Diabetes                           | _____ Hearing impairment             |
| _____ Stomach or colon problems          | _____ Depression or severe anxiety   |
| _____ Lung problems/COPD/asthma          | _____ Alcoholism                     |
| _____ Reflux                             | _____ Chemical dependency or abuse   |
| _____ Fibromyalgia                       |                                      |
| _____ Stroke                             | <b><u>Female</u></b>                 |
| _____ TIA (“light stroke”)               | _____ Premenstrual Syndrome          |
| _____ Blackouts                          | _____ Menopause                      |
| _____ Seizures                           | <b><u>Male</u></b>                   |
| _____ Back or joint problems (arthritis) | _____ Prostate problems              |
| _____ Cancer                             | _____ 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

- Frequent headaches
- Fainting or passing out
- Sudden loss of vision, strength, inability to speak
- Hearing loss or ringing in ear(s)
- Hoarseness for more than 2-4 weeks
- Nosebleeds
- Cough for more than 2-4 weeks
- Coughing up blood
- Shortness of breath or wheezing
- Swelling in feet or ankles
- Chest pain, chest pressure or heaviness
- Irregular heartbeat or sudden fast heartbeat
- Difficulty swallowing or food "sticking"

Yes No

- Frequent heartburn or indigestion
- Abdominal pain
- Frequent constipation
- Frequent diarrhea
- Rectal bleeding/black stools
- Difficulty urinating/incontinence
- Blood in urine
- Urinating more than 2 times per night
- Pain in joints or bones
- Unusual bruising or bleeding
- Convulsions
- Change in wart, mole or skin growth
- Weight loss of more than 5-10 lbs.

**Family History**

Has an immediate blood relative had any of the following?

Yes No

- |   |                 |       |
|---|-----------------|-------|
| <input type="checkbox"/> <input type="checkbox"/> Cancer        | <u>Relation</u> | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes      | <u>Relation</u> | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Hypertension  | <u>Relation</u> | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Heart disease | <u>Relation</u> | _____ |

Yes No

- |  |                 |       |
|--|-----------------|-------|
| <input type="checkbox"/> <input type="checkbox"/> Stroke             | <u>Relation</u> | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Anxiety/Depression | <u>Relation</u> | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Sleep apnea        | <u>Relation</u> | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Narcolepsy         | <u>Relation</u> | _____ |

Thyroid disease \_\_\_\_\_  
  Father alive: Age \_\_\_\_ Died @ age \_\_\_\_

Other: \_\_\_\_\_  
  Mother alive: Age \_\_\_\_ Died @ age \_\_\_\_

<b>Answer Key: 1 – Not Sure      2 – Never      3 – Sometimes      4 – Often</b>				
	<b>Not Sure</b>	<b>Never</b>	<b>Sometimes</b>	<b>Often</b>
<i>Using the above answer key, please circle the number that best applies to your life over the past 6 months:</i>				
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)	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
My snoring or my breathing problem is much worse if I sleep on my back	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
My snoring or my breathing problem is much worse if I fall asleep right after drinking alcohol	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>

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**

**2 = Often occurs**

**1 = Occasionally occurs (25% of the time or less)**

**3 = Usually occurs (75% of the time or more)**

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