McLaren
GREATER LANSING

Sleep & Alertness Center
2727 S Pennsylvania Ave, Lansing, MI 48910
P#: (517) 975-3375 F#: (517) 975-3390

Sleep Questionnaire

Appointment Date/Time : _____

Please complete along with the bed partner questionnaire (if applicable) and sleep diary and bring with you to your appointment. If you have any questions please call (517) 975-3375.

Name: _____ Date of Birth:_____ Age: _____ Sex: _____

Today's Date: _____ Height: _____Inches Weight: _____Lbs

Weight 1 year ago: _____Lbs Weight 5 years ago: _____Lbs

What is your main sleep related problem? _____

_____

_____

How long have you had this problem? _____

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 times do you work? _____

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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 more than twice 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 drowsy**?	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	Yes	No
Do you **kick or jerk** your arms or legs during sleep?	Yes	No
Have you experienced an **urge to move** your legs accompanied by an **uncomfortable sensation**?	Yes	No
Do you have an urge to move your **legs** that **worsens with rest or inactivity** like lying down or sitting?	Yes	No
Do you have an urge to move your **legs** that is **relieved by walking or stretching**?	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
Do you **grind** your teeth?	Yes	No

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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

Who prescribed? _____ What pressure setting? _____

Do you use home **oxygen**? YES NO

What liter/flow setting? _____

Do you have a **pacemaker/defibrillator with pacemaker**? YES NO

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 problems.

☐ Hypertension
☐ Heart Attack
☐ Congestive Heart Failure
☐ Sexual dysfunction/ loss of libido
☐ Diabetes
☐ Lung problems/ COPD/Asthma
☐ Stroke/ TIA
☐ Acid Reflux (heartburn)
☐ Arthritis
☐ Fibromyalgia
☐ Cardiac Arrhythmias
☐ Depression
☐ Anxiety
☐ Seizures
☐ Dementia
☐ Claustrophobia

Other_____

_____

FAMILY HISTORY *Does any member of your family have the following?*

Sleep Apnea?	YES	NO	Relationship	_____
Narcolepsy?	YES	NO	Relationship	_____
Seizure disorder?	YES	NO	Relationship	_____
Depression?	YES	NO	Relationship	_____
Hypertension?	YES	NO	Relationship	_____
Stroke?	YES	NO	Relationship	_____
Heart Disease?	YES	NO	Relationship	_____
Psychiatric illness?	YES	NO	Relationship	_____
Other Disorder?			Relationship	_____

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MEDICATIONS (please list, attach a separate sheet if necessary)

Medication	Dose	# Times/Day	Medication	Dose	#Times/Day

Allergies (please list)

REVIEW OF SYSTEMS

(Please check where appropriate if you have had any of these symptoms in the last 12 months).

- ☐ Frequent headaches
- ☐ Fainting or passing out
- ☐ Difficulty understanding instructions
- ☐ Difficulty giving instructions
- ☐ Difficulty following instructions
- ☐ Decreased short term memory
- ☐ Difficulty organizing thoughts
- ☐ Difficulty planning activities/trips
- ☐ Sudden loss of Vision, strength
- ☐ Hearing loss or ringing in ears
- ☐ Nosebleeds
- ☐ Cough for more than 2 weeks
- ☐ Coughing up blood
- ☐ Shortness of breath/wheezing
- ☐ Swelling in feet or ankles
- ☐ Chest pain or heaviness
- ☐ Irregular heartbeat
- ☐ Difficulty swallowing
- ☐ Abdominal pain
- ☐ Frequent heartburn
- ☐ Frequent constipation
- ☐ Frequent diarrhea
- ☐ Rectal bleeding/black stools
- ☐ Difficulty urinating/incontinence
- ☐ Blood in urine
- ☐ Urinating more than 2 times a night
- ☐ Pain in bones or joints
- ☐ Unusual bruising or bleeding
- ☐ Convulsions
- ☐ Change in wart, mole or skin growth
- ☐ Weight loss of more than 5-10 lb
- ☐ Other (describe) _____

_____

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SOCIAL HISTORY *(please circle answer and fill in the blank where appropriate)*

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

Previous jobs held _____

Marital status_____ Do you share a bed with someone? YES NO

Do you smoke? YES NO Packs per day? _____ How long? _____

Have you smoked in the past? YES NO Packs per day? _____ How long? _____
If you quit, when?_____

Do you drink beer, wine, or liquor? YES NO How much? _____ How long? _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired. Please circle the most appropriate answer using the following scale.

0 = never	1 = occasionally	2 = often	3 = usually

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
At a public place like a theater or meeting	0	1	2	3
While a passenger in a car for one hour or more	0	1	2	3
Lying down in the afternoon	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting down after lunch	0	1	2	3
Stopped at a stoplight	0	1	2	3

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

Signature: _____ Date: _____

Please circle one of the following (Patient/guardian/caretaker)

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