MICHIGAN INSTITUTE FOR SLEEP MEDICINE – NEW PATIENT SLEEP QUESTIONNAIRE

Please bring copies of any recent Blood Work and Physician Sleep Referral Order

Please answer every question to the best of your ability. It is helpful to discuss the answers with someone who has witnessed your problems, such as a spouse or bed partner. ***All results are published via the Patient Portal, Email is Required***

Date:______________________________ Email:____________________________________

Name:________________________________Date of Birth:___/___/____Age:_________Sex:____________

Address:________________________________City:_____________________________Zip:____________

Home Phone: ( )______________________Cell Phone: ( )___________________(optional)

SS#__________________________Marital Status:_____________Occupation:___________________

Employer:____Work Phone: ( )______________

Spouse: (If applicable)

Name:______________________________________ Date of Birth:____/___/____________

Employer:____________________________________ Work Phone: ( )____________________

Emergency Contact:_______________________________ Relationship:___________________

Daytime Phone:_____________________________Evening Phone: ( )__________________________

Referring Physician:_______________________________M.D. / D.O. Phone: ( ) _________________
(Circle one)

Address:___________________________________City:___________________________Zip: ___________

Primary Care Physician:____________________________M.D. / D.O. Phone: ( ) __________________
(Circle one)

Address:___________________________________City:__________________________Zip:___________

Please describe your sleep or sleep problem____

When did your sleep problem begin?____________Have you ever been treated for snoring, sleep apnea,

sleepiness or insomnia? **Yes** or **No,** If yes, who?____

Please describe the treatment ____

Have you ever had a sleep study? **Yes** or **No** If yes, where?_______________________________

MEDICAL HISTORY
Have you ever been told by a doctor that you have:

YES
( ) Hypertension (high blood pressure)
( ) Thyroid gland problems
( ) Heart attack
( ) Angina
( ) Stroke
( ) Cancer
( ) Kidney disease

YES
( ) Asthma
( ) Emphysema or chronic bronchitis
( ) Depression or other psychiatric disorders
( ) Sinusitis
( ) Liver disease
( ) Diabetes

Do you have other medical problems? If so, please list them here: ______________________________________

____

Surgical History/Hospitalizations:

( ) Tonsillectomy (tonsils taken out) ( ) History of trauma
( ) Other surgeries/hospitalizations____

____

Your Height:___________ **Weight:** ___________
Has your weight changed? **Yes** or **No** If yes, How much? How long ago?

METHOD OF LEARNING WHICH WORKS BEST FOR YOU?
______ Reading ______Watching a video ______Observing

SOCIAL HISTORY:

Married________Single_______Widow______Divorced________

# of children________If you have children, do they live with you? Yes / No

Do you smoke cigarettes, cigars or a pipe?
Yes–packs/day___________ years ________________
Quit–packs/day__________ # years smoked_________quit _______
Never smoked___________

How much of the following do you use:

	Per weekday	Per weekend day
Coffee Tea	__________	___________
Chocolate	__________	___________
Caffeinated soda	__________	___________
Alcohol	__________	___________
Recreational drugs	__________	___________
Energy drinks	__________	___________

SLEEP HABITS

	Weekdays	Weekends
What time do you go to bed?	________am/pm	______________am/pm
What time to you get up?	________am/pm	______________am/pm
How long does it take you to fall asleep?	________min/hrs	_____________min/hrs
On average, how many hours of actual sleep do you get nightly?	_______hours	______hours
On average, how many times do you wake up during the night?	_______times	_______times
Do you return to bed after arising?	**Yes / No**	**Yes / No**
What time do you go to work or school?	______am/pm	______am/pm
What time do you return home?	______am/pm	______am/pm

Does your job require working different shifts? **Yes / No** If yes, which shifts? ____________________

Do you take naps? **Yes No.** If yes how often during the day_________, the evening _______________

What do you do at night when you wake up?_______________________________________

Do you worry about your sleep problem during the daytime? **Yes / No**

How do you sleep away from home (e.g. on a vacation)?____

Do you watch T.V., read, eat, etc. in bed? **Yes / No**

Do you fall asleep more easily on the couch than in bed? **Yes / No**

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	**Chance of Dozing**
Sitting and reading?..	______________
Watching TV?..	______________
Sitting inactive in a public place (e.g., a theater or a meeting).?...........................	_____________
As a passenger in a car for an hour without a break?...	______________
Lying down to rest in the afternoon when circumstances permit?......................	______________
Sitting quietly after a lunch without alcohol?...	_____________ _
Sitting and talking to someone? ………………………………………………..	______________
In a car, while stopped for a few minutes in traffic?..	_______________
Total	_______________

SLEEP SYMPTOMS

1. Do you snore?...yes / no
2. Does your snoring prevent somebody from sleeping in the same bed with you?...... yes / no
3. Do you wake up gasping or feeling you can't breathe?...yes / no
4. Has your bed partner ever told you that you stop breathing during sleep?................ yes / no
5. Do you wake up with a headache?...yes / no
6. Do you have a restless or creepy feeling in your legs that is decreased by moving your legs or walking or prevents you from sleeping?..................................… yes / no
7. Has your bed partner ever noticed leg movements while you were sleeping?..........… yes / no
8. Does your bed partner complain that you kick them during the night?....................… yes / no
9. If so, does it prevent him or her from sleeping in the same bed with you?.............……yes / no

10. Do you toss and turn?.. yes / no

11. Do you wake up feeling tired, disoriented, foggy?... yes / no

12. Have you ever had an automobile accident related to sleepiness?.............................. yes / no

13. Have you ever had accidents at work related to sleepiness?...................................... yes / no

14. Do you ever find yourself somewhere and do not know how you got there?............... yes / no

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15. Do you have vivid dreams shortly after falling asleep at night?................................. yes / no

16. Do you ever feel that you cannot move after lying down or just after you wake?.......yes / no

17. Do you ever feel sudden weakness in your limbs when laughing emotionally?............yes / no

18. When you wake up, are you short of breath or wheezing?.. yes / no

19. Do you grind your teeth at night?.. yes / no

20. Do you wake up during the night for no apparent reason?...yes / no
If yes, do you have trouble going back to sleep..yes / no

21. Do you wake up during the night and have trouble going back to sleep?.................. yes / no

22. Do you wake up early in the morning and cannot go back to sleep?........................... yes / no

23. Do you wake up at nights with thoughts racing through your mind?.......................... yes / no

24. Do you get up more than once a night to urinate?.. yes / no

25. Do you have difficulty falling asleep or wake up frequently throughout
the night because of pain?...yes / no

26. Are you easily awakened by noise or light?...yes / no

27. Do you feel frustrated or tense when seeing your bed or bedroom?...............................yes / no

28. Have you felt depressed recently?...yes / no

29. Have you been having marital conflict lately?..yes / no

30. Do you have job stress?...yes / no

31. Do you find it difficult to get out of bed in the morning?...yes / no

32. Is your job or school performance affected by your sleep problem?................................yes / no

Review of Systems

Do you presently have?

General:	Y	N	Eyes:	Y	N	Ears:	Y	N
Fever/Chills	☐	☐	Dry Eyes	☐	☐	Difficulty Hearing	☐	☐
Night sweats	☐	☐	Vision Change	☐	☐	Ear Pain	☐	☐
Change in Weight	☐	☐	Eye Irritation	☐	☐			
Exercise Intolerance	☐	☐						

Nose:	Y	N	Mouth:	Y	N	Cardiac:	Y	N
Frequent Nose Bleeds	☐	☐	Sore Throat	☐	☐	Chest Pain	☐	☐
Nose Problems	☐	☐	Bleeding Gums	☐	☐	Heart Palpitations	☐	☐
Sinus Problems	☐	☐	Dry Mouth	☐	☐	Heart Murmurs	☐	☐
			Mouth Ulcers	☐	☐			
			Teeth Problems	☐	☐			
			Mouth Breathing	☐	☐			

Respiratory:	Y	N	Gastrointestinal:	Y	N	Urinary:	Y	N
Cough	☐	☐	Abdominal Pain	☐	☐	Incontinence	☐	☐
Wheezing	☐	☐	Nausea/Vomiting	☐	☐	Difficulty urinating	☐	☐
Shortness of Breath	☐	☐	Diarrhea	☐	☐	Blood in Urine	☐	☐
Coughing Up Blood	☐	☐	Black or tarry stool	☐	☐	Increased Frequency	☐	☐
			Vomiting Blood	☐	☐	Incomplete Emptying	☐	☐
			GERD	☐	☐			

Muscles/Skeletal:	Y	N	Skin:	Y	N	Neurologic:	Y	N
Muscle Aches	☐	☐	Abnormal Mole	☐	☐	Loss of Consciousness	☐	☐
Muscle Weakness	☐	☐	Jaundice	☐	☐	Weakness	☐	☐
Arthralgias/Joint Pain	☐	☐	Rashes	☐	☐	Numbness	☐	☐
Back Pain	☐	☐	Laceration	☐	☐	Seizures	☐	☐
Swelling Extremities	☐	☐	Itching	☐	☐	Dizziness	☐	☐
			Dry Skin	☐	☐	Headaches	☐	☐
			Growths/Lesions	☐	☐	Migraines	☐	☐

Emotion:	Y	N	Endocrine:	Y	N	Hematologic:	Y	N
Depression	☐	☐	Fatigue	☐	☐	Swollen Glands	☐	☐
Alcohol Abuse	☐	☐	Increased Thirst	☐	☐	Bruising	☐	☐
			Hair Loss	☐	☐	Excessive Bleeding	☐	☐
			Hair Growth	☐	☐			
			Cold intolerance	☐	☐			

Allergy:	Y	N
Runny Nose	☐	☐
Pressure	☐	☐
Itching	☐	☐
Hives	☐	☐
Frequent Sneezing	☐	☐