ST. JOSEPH MERCY OAKLAND
SAINT JOSEPH MERCY HEALTH SYSTEM

Medical and Sleep Questionnaire

Name: _____ Date: _____

Please complete the following questions to help us evaluate your sleep problem. Your bed partner, or family may more easily answer some of the questions. Please bring this completed questionnaire to your office appointment. Please call **248-371-1726** if you have any questions.

Date of Birth _____ Age _____
Height _____Weight _____lbs

Referring Physician :
_____
Address _____
_____
_____
Telephone number _____

Primary Care Physician :
_____
Address _____
_____
_____
Telephone number _____

Other Professional you would like reports to be sent:
Name _____
Address _____
_____
_____
Telephone Number _____

Reason for your visit:
_____
_____
_____

Sleep Disorders Center
3100 Cross Creek Parkway, Suite 210, Auburn Hills, MI 48326, Office: 248.371.1726, Fax: 248.371.1835

Medical and Sleep Questionnaire

Name: _____ Date: _____

	Workday's	Non-work days/ Weekends
What time do you usually go to bed?	_____ am/pm	_____ am/pm
How soon after you go to bed do you turn off the lights?	_____ min	_____ min
On average, how long does it take to fall asleep after turning off the lights?	_____ min	_____ min
Do you awaken during the night?	__ yes__no	__yes__ no
Is it predictable?	__ yes__no	__yes__ no
If so, what times are you awakening?	___: ___ , ___: ___	___: ___ , ___:___
Do you wake up naturally?	__yes__no	__yes__no
Do you use an Alarm Clock?	__yes__no	__yes__no
If so what time is it set at?	___: ___ AM/PM	___:___AM/PM
How many times do you hit the snooze	_____	_____
What time do you usually wake up for the day?	_____ am/pm	_____am/pm
What time do you get out of bed?	_____ am/pm	_____ am/pm
How many naps or rest periods do you take during the week?	_____	_____
If so, at what time (s)	__: ___ to___: ___	___: ___to ___:___
How many times do you try to take a nap but can't fall asleep?	_____	_____

PLEASE FILL OUT THE SLEEP LOG

Questions regarding sleep related symptoms are included on later pages in the questioner. Please add here any other comments you would like to mention about the timing of your **sleep routine/habits** not covered above or in the sleep log**.**

_____

Medical and Sleep Questionnaire

Name: _____ Date: _____

_____
_____

Rarely	Sometimes	Often	Always		***Never***
				While trying to fall asleep do you feel sad and depressed, or worry about things, or have thoughts racing through your mind?	
				While trying to fall asleep do you experience restless legs, crawling or aching feelings, or an inability to keep legs still?	
				How often do you use non-drug techniques such as biofeedback, hypnosis, relaxation techniques, special diets, or sex activity to help you go to sleep?	
				Do you have restless sleep or disturbed sleep?	
				Do your legs twitch or kick while you are asleep?	
				How often have you disturbed the sleep of your bed-partner do to restlessness?	
				How often do you snore or how often have people complained that you snore?	
				Has anyone ever noticed that your breathing and/or snoring are variable, or that it pauses or stops at times?	
				Do you awaken in the morning with a dry mouth?	
				Do you awaken from sleep with shortness of breath?	
				Do you awaken with your heart racing?	
				Do you awaken with a Headache?	
				Do you walk in your sleep?	
				Do you talk in your sleep?	
				Do you grind your teeth during your sleep?	
				Do you get up at night to eat?	
				Do you make rocking or rolling movements during sleep?	
				Have you ever fallen out of bed while asleep?	
				Do you awaken from sleep screaming, violent,	

Medical and Sleep Questionnaire

Name: _____ Date: _____

				and confused?	
				Do you wet your bed?	
Rarely	Sometimes	Often	Always		***Never***
				Have you been told that you have had a "convulsion" or seizure during sleep? Do you carry a diagnosis of epilepsy?	
				Do you ever awaken from pain or are you restless due to pain? e.g. arthritis, back pain, muscle pain, etc.	
				Do you awaken or are you bothered by Gastroesophageal reflux or Heartbearn at night?	
				Do you suffer from nasal or sinus congestion that results in awakening, restlessness, or an inability to initiate or maintain sleep?	
				How often do you wake feeling refreshed and ready to go?	
				Do you notice that it is unusually difficult to wake up in the morning?	
				Do you awaken from sleep at a predetermined time just by yourself <u>without alarm clocks or just before your alarm clock goes off?</u>	
				Do you feel unable to move or paralyzed when waking up?	
				Do you have dream-like images (hallucinations) when awakening even though you know that you are not asleep?	

Name: _____ Date: _____

				Have you ever had a sudden weakness or loss of strength after an emotional situation, either happy or upsetting? (e.g. laughter or anger) *Example: You hear a funny joke in a public place, you laugh and feel weak suddenly falling to the ground.*	

Rarely	Sometimes	Often	Always		***Never***
				Do you have a problem with SLEEPINESS, struggling to stay awake in the daytime?	
				Do you have a problem with FATIGUE, feeling tired, exhausted, and lethargic even when you are not sleepy?	
				Do you have difficulty concentrating?	
				Are you forgetful?	
				Are you irritable?	
				Do you feel as though you don't have enough energy to do things that you previously enjoyed such as hobbies?	
				Do you feel depressed?	
				Do you have a problem with your performance at work because of sleepiness or fatigue?	
				Have you ever had accidents at work because of sleepiness or fatigue?	
				Have you ever been involved in an auto accident caused by sleepiness?	
				Have you ever had a "near miss" while driving due to sleepiness?	
				Have you ever fallen asleep while stopped in traffic or at a traffic signal.	
				Do you usually feel restored or refreshed after a nap, a rest, or a nighttime sleep?	
				If you do take naps, how often are the naps	

Name: _____ Date: _____

				refreshing? If so how long? ____hours _____min	
				Do you experience vivid dream-like images (hallucinations) while falling asleep or awakening from a nap even though you know you are still wake?	
				Did you ever drive somewhere and not remember the period of time or the process of driving there.	

Name: _____ Date: _____

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these tings 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**	
	Patients Impression	**Family/Friends Impression**
Sitting and reading	_____	_____
Watching TV	_____	_____
Sitting, inactive in a public place(i.e. a theater or meeting)	_____	_____
As a passenger in a car.	_____	_____
Lying down to rest in the afternoon	_____	_____
when circumstances permit.	_____	_____
Sitting and talking to someone	_____	_____
Sitting quietly after a lunch without alcohol.	_____	_____
In the traffic	_____	_____
Total:	_____	_____

Name: _____ Date: _____

Medical History
Please list all your medical problems:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list your previous surgical procedures, dates, and any complications:

Procedure	**Date**	**Complication**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all medications and allergies on the medication sheet attached.

Name: _____ Date: _____

Family History

Please list any medical problems in your family:

Relative			Medical Problems
Father	___age/living	___age/deceased	_____
Mother	___age/living	___age/deceased	_____
Siblings			
__B/S__	___age/living	___age/deceased	_____
__B/S__	___age/living	___age/deceased	_____
__B/S__	___age/living	___age/deceased	_____

Does any member of your family have a sleep disorder? _____ yes _____ no
If so please describe:_____

Social History

Please list your occupation:
_____
What is your normal work schedule? Start time ____:____ End Time ____:____
Do you smoke? _____ yes _____ no
If yes, how many packs per day? _____ How many years? _____
Do you drink alcoholic beverages? _____ yes _____ no
If yes, how many drinks per day? _____ For how many years? _____
Do you drink coffee, tea, cola or other caffeinated beverages? _____ yes _____no
If yes, how many cups/glassed per day? _____
Do you exercise regularly? _____yes _____no
If yes, what type of exercise and how many times per week?_____
_____

Name: _____ Date: _____

Systems Review

Constitutional				
Recent weight change	No	Yes	Explain	_____
Fatigue	No	Yes	Explain	_____
Night sweats	No	Yes	Explain	_____
Eyes				
Have corrective lens (glasses/contact lens)	No	Yes	Explain	_____
Do you wear them	No	Yes	Explain	_____
Ears/Nose/Mouth/Throat				
Hearing loss or ringing	No	Yes	Explain	_____
Earaches or drainage	No	Yes	Explain	_____
Chronic sinus problem	No	Yes	Explain	_____
(congestion or drainage)	No	Yes	Explain	_____
Recurrent sinus infections	No	Yes	Explain	_____
nose bleeds	No	Yes	Explain	_____
Voice change or hoarseness	No	Yes	Explain	_____
TMJ pain	No	Yes	Explain	_____
Cardiovascular				
Chest pain or angina	No	Yes	Explain	_____
Palpitations	No	Yes	Explain	_____
Shortness of breath lying flat	No	Yes	Explain	_____
Swelling of ankles or feet	No	Yes	Explain	_____
History of Phlebitis	No	Yes	Explain	_____
Respiratory				
Chronic cough	No	Yes	Explain	_____
Frequent bronchitis	No	Yes	Explain	_____
Shortness of breath	No	Yes	Explain	_____
Asthma or wheezing	No	Yes	Explain	_____
Coughing up blood	No	Yes	Explain	_____
Gastrointestinal				
Do you eat regularly	No	Yes	Explain	_____
Change in bowel movements that interfere with sleep	No	Yes	Explain	_____
Nausea or vomiting during sleep	No	Yes	Explain	_____
Heartburn or reflux during sleep	No	Yes	Explain	_____
Hematologic/Lymphatic				
Anemia	No	Yes	Explain	_____
Musculoskeletal				
Joint pain	No	Yes	Explain	_____

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Joint stiffness or swelling	No	Yes	Explain	_____
Muscle pain or cramps	No	Yes	Explain	_____
Back pain	No	Yes	Explain	_____

Systems Review cont.

Genitourinary

Do you awaken to urinate	No	Yes	Explain	_____
Increased daytime urination	No	Yes	Explain	_____
Burning or painful urination	No	Yes	Explain	_____
Blood in urine	No	Yes	Explain	_____
Decreased urinary stream	No	Yes	Explain	_____
Involuntary loss of urine	No	Yes	Explain	_____
Enlarged prostate	No	Yes	Explain	_____

Integument (Skin)

Rash or itching that affects sleep	No	Yes	Explain	_____
Varicose veins	No	Yes	Explain	_____

Neurological

Frequent or recurring headaches	No	Yes	Explain	_____
Tremors	No	Yes	Explain	_____
Seizures	No	Yes	Explain	_____

Psychiatric

Memory loss or confusion	No	Yes	Explain	_____
Nervousness or anxiety	No	Yes	Explain	_____
Depression or mood swings	No	Yes	Explain	_____
Poor attention span	No	Yes	Explain	_____

Endocrine

Excessive thirst	No	Yes	Explain	_____
Heat or cold intolerance	No	Yes	Explain	_____
Skin becoming dryer	No	Yes	Explain	_____

Allergic

Tape or latex allergy	No	Yes	Explain	_____
Seasonal Allergies	No	Yes	Explain	_____

Name: _____ Date: _____

MEDICAL INFORMATION FORM

Name:

_____

Last (Please Print) First M.I.

Signature: _____Date: _____

Please list all medication you are currently taking:

Name of Medication	**Dosage**	**Times Per Day**

Please list any medications to which you are allergic:

_____ _____
_____ _____

Other Allergies:

_____ _____
_____ _____