MUNSON MEDICAL CENTER
Sleep Disorders Center
MUNSON HEALTHCARE

Name: _____ DOB: _____ Date: _____

Please complete this questionnaire and BRING WITH YOU to your consultation.

Describe your sleep concerns:

_____

_____

How long have you had sleep problems:

_____

Have you ever had a sleep study? ☐ NO ☐ YES

If yes, when and where? _____

Do you have trouble falling asleep:

☐NO ☐YES: ☐Daily ☐1-2x/week ☐3-5x/week

Staying asleep:

☐NO ☐YES: ☐Daily ☐1-2x/week ☐3-5x/week

~~~~~~~~~~ ON AVERAGE ~~~~~~~~~~

How long does it take you to fall asleep:

☐ 0-10 min ☐ 15-30 min ☐ 1-2 hours

☐ longer: _____

How many times do you wake up?_____

What wakes you up?_____

☐ Unsure ☐ Snoring ☐ Gasping or Choking

☐ Pain Shortness of breath ☐ Need to urinate

How long are you then awake?_____

How many hours do you sleep?_____

What time do you:

Go to bed _____ Fall asleep _____

Get up on work days _____ Get up on days off _____

Are you told that you snore? ☐ NO ☐ YES

Are you told that you stop breathing during sleep?

☐ NO ☐ YES: how long? _____

Where do you normally sleep:

☐ Bed ☐ Recliner ☐ Adjustable bed

☐ Other: _____

What is your occupation _____

What hours do you work _____

Do you feel refreshed when you wake up? ☐ NO ☐ YES

DURING SLEEP do you experience:

Heart Palpitations ☐ NO ☐ YES

Indigestion or Reflux ☐ NO ☐ YES

Nasal congestion ☐ NO ☐ YES

Teeth grinding ☐ NO ☐ YES

Do you wear a bite splint ☐ NO ☐ YES

Pain Scale 0 1 2 3 4 5 6 7 8 9 10

Pain Location:_____

Does your mind race making it difficult to fall or stay asleep: ☐ NO ☐ YES

Do you experience Depression or Anxiety?

☐ NO ☐ YES

Have you become increasingly irritable or short tempered? ☐ NO ☐ YES

Do you feel tired or sleepy during the day?

☐ NO ☐ YES Time of day: _____

Do you take NAPS during the day? ☐ NO ☐ YES

☐ Daily ☐ 1-2x/week ☐ 3-5x/week

☐ Other: _____

How long are your naps? _____

Are naps refreshing? ☐ NO ☐ YES

Would you take naps if you had the chance?

☐ NO ☐ YES

Do you fall asleep at work or at meetings?

☐ *Never* ☐ *Rarely* ☐ *3-5x/week* ☐ *Daily*

Do you sleep walk, sleep eat, or sleep talk?

☐ NO ☐ YES How often: _____

Do you have nightmares, dreams

☐ NO ☐ YES How often: _____

Do you experience symptoms of Restless Leg Syndrome?

This is described as an unpleasant sensation in your legs with an urge to move or stretch your legs to make them feel better.

These symptoms often begin while sitting to relax or at bedtime.

☐ NO ☐ 1-2x/ Month ☐ 1-2x/week ☐ Daily

Are you restless during sleep? ☐ NO ☐ YES

Have you: Acted out your dreams, Fought or punched? Jumped or fallen out of bed? Injured yourself or your bed partner? ☐ NO ☐ YES

Describe: _____

When falling asleep or waking up, have you ever felt as if you were awake but paralyzed for a short while (not numbness or tingling of arms or legs)?

☐ Never ☐ Rarely ☐ 3-5x/week ☐ Daily

Do you ever feel as though you are imagining (seeing or hearing things) as you fall sleep or when you are waking up?

☐ Never ☐ Rarely ☐ 3-5x/week ☐ Daily

Do you experience episodes of muscle weakness, loss of muscle strength, or limp muscles such as your head dropping, your legs giving out, or you fall to the floor when you: *laugh* or *tell a joke* or are *angry*?

☐ NO ☐ YES

While DRIVING: do you get sleepy, drowsy, tired, or fatigued?

☐ Never ☐ Rarely ☐ 3-5x/week ☐ Daily

Do you pull off the road to nap or rest:

☐ NO ☐ YES

Have you crossed the center line or run off to the side of the road while driving drowsy:

☐ NO ☐ YES: _____X's/year _____X's/month

Do you have a commercial driver's license or applying? ☐ NO ☐ YES

Do you wake up with headaches? ☐ NO ☐ YES

How often? _____

Describe: _____

PAST MEDICAL HISTORY:

	High Blood Pressure		**Diabetes**
	High Cholesterol		**Stroke/TIA**
	Atrial Fibrillation		**Heart attack**
	Anemia		**Heart disease**
	Nasal Allergies		**Asthma**
	COPD/lung disease		**Hypothyroidism**
	Seizures		**Closed head injury**
	Depression/Anxiety		**Bipolar Depression**
	Compulsive disorder		**Back Pain**
	Peripheral Neuropathy		**Fibromyalgia**
	Arthritis		**Melanoma**
	Other skin cancer? Cell type		
	Other		

PAST SURGERIES:

	Tonsillectomy/Adenoidectomy		**Uvuloplasty**
	Deviated Septum Repair		**Sinus surgery**
	Back Surgery		**Gall Bladder**
	Coronary artery bypass ...when		
	Heart Stents ...when		**Thyroidectomy**
	Joint replacement...joint		
	Hernia Repair		**Carpal Tunnel**
	Hysterectomy		**Ovaries**
	Removal of skin cancers...which cell type?		
	Other Surgeries:		

YOUR MEDICATIONS & Doses/Times
(include over the counter and herbal meds)

PLEASE LIST OR ATTACH

_____

_____

_____

_____

_____

_____

Do you have Medication allergies? ☐ NO ☐ YES

List allergies: _____

_____

Do you smoke: ☐ NO ☐ YES

_____ packs/day How long? _____ years

List the beverages that you drink: Amount /Time of day

Regular coffee or tea _____

Caffeinated Soft drinks _____

Alcohol (beer/wine/cocktails) _____

Marijuana:

Medical: ☐ NO ☐ YES
Recreational: ☐ NO ☐ YES
CBD Oil: ☐ NO ☐ YES

What is your weight? Now_____

1 yr ago _____ 5 yrs ago _____

Marital Status: _____

Living Situation: _____

Do sleep problems run in your family? Sleep Apnea, Insomnia, Restless Legs, and Narcolepsy

If Yes which family member? _____

Take the following sleep quiz to see if you are sleepy.
The Epworth Sleepiness Scale

If you had the chance to do this during your day, could you doze?

Score:

0 = No chance 1 = Slight chance of dosing
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 (church)	_____
As a passenger in a car for 1 hour	_____
Lying down to rest in the afternoon	_____
Sitting and talking with someone	_____
Sitting quietly after lunch without alcohol	_____
Driving a car, stopped for a few minutes in traffic	_____
Total	_____

1. **Snoring:** Do you snore loudly (partner nudges you or you can be heard through closed doors)?
   ☐ NO ☐ YES

2. **Tired:** Do you often feel tired, fatigued, or sleepy during the daytime?
   ☐ NO ☐ YES

3. **Observed:** Has anyone observed you stop breathing during your sleep?
   ☐ NO ☐ YES

4. **Blood pressure:** Do you have or are you being treated for high blood pressure?
   ☐ NO ☐ YES

5. **BMI:** BMI more than 35 kg/m2?
   ☐ NO ☐ YES

6. **Age:** Age over 50 yrs. old?
   ☐ NO ☐ YES

7. **Neck circumference:** Neck circumference 40 cm (15-3/4 in.) or greater?
   ☐ NO ☐ YES

8. **Gender:** Male?
   ☐ NO ☐ YES

Family Health Conditions (parents, siblings): _____

_____

_____

_____

Please fill this out and bring with you for your consultation.

Please bring a list of all your medications you are currently taking and a list of all allergies with you for your sleep consultation