SLEEP DIORDERS CENTER PHONE: (231) 935-9307

MUNSON HEALTHCARE

The answers to the following questions will help the provider better understand your medical history. Although every question may not apply to the problem that you have come to see the provider about, your answers will assist in developing a complete picture of your overall health.

Name: _____ □ M □ F □ Other_____

Phone: (_____) _____- _____

Age: _____

Marital Status □ single □ married □ divorced □ other_____

Living situation □ self □ significant other □ family □ other_____

Primary Care Physician: _____ Referring Physician: _____

Previous diagnosis of sleep apnea _____ What year was sleep study _____

Have tried CPAP or BiPAP □ Current _____ □ Past (what year) _____

Any one in **family with sleep apnea** _____

Current Medical Conditions: □ Heart Disease □ Stroke □ Kidney Disease □ High Blood Pressure □ Heart Burn □ Thyroid problems □ COPD/Asthma □ Edema □ Overeating □ Depression/anxiety □ Atrial Fibrillation

Tonsils: □ present □ removed (what year) _____

Current Medications (or attach list): _____

_____

_____

Are you currently **on oxygen** at home? _____ How much? _____

My occupation is/was_____

Allergies to Medications (please list):_____ _____ Do you drink caffeinated beverages: _____ How many:(include coffee, pop and energy drinks) _____ What time is the last one for the day? _____ Do you drink alcohol: _____ □ never □ sometimes □ often □ rarely drink alcohol How many alcoholic beverages do you consume per week. _____	Are you a tobacco user? (circle one) Yes No How much tobacco you use a day. PPD_____ If quit when: _____ Vaping____ THC_____ Who completed this questionnaire? _____ If not the patient, how often do you directly observe the patient's sleep? □ Frequently □ Occasionally □ Never

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Place a check beside any of the following statements that are true:

□ I have **trouble going to sleep** at night	□ I have been told that I have convulsions, fits, or **seizures** at night.
□ I have **difficulty staying asleep** and wake up frequently.	□ I have bitten my tongue while asleep
□ When I wake up during the night, I have **trouble going back to sleep.**	□ As an adult, I have wet my bed
□ I wake up in the morning long before I have to	□ As an adult, I have been seen **sleepwalking**
□ I frequently can't sleep in the bedroom but can get up and sleep in another room on a couch, recliner, etc.	□ As an adult, I have been **sleep talking**
□ I have a job that involves **night work.**	□ I sometimes **fall asleep unintentionally.**
□ I have a job that involves **revolving shift work.**	□ I am frequently so sleepy when working that my work is poor.
□ I have difficulty falling sleep because my **legs a are jumpy.** (charley horses, creepy crawly feelings)	□ I have had accidents when driving because I felt so sleep.
□ I sometimes wake up with **feelings of aching or "pins and needles" in my legs.**	□ I have sometimes fallen asleep at very inappropriate times, such as driving, eating or during a conversation.
□ I have been told that I **snore**	□ I've had the sensation of a sudden **weakness in my legs, arms, face or whole body <u>occurring on both sides equally</u>,** while awake, usually occurring in emotional situations, such as when laughing, crying, when angry, startled, etc.
□ I've been told that I **stop breathing** when I sleep.	□ I have **hallucinations or dream like images** when I am not actually asleep but while falling asleep or waking up.
□ I sometimes awaken with a **choking** sensation	□ I sometimes have **felt paralyze**d or unable to move when waking up or falling asleep.
□ I have been told that I am **restless** at night	□ My **dreams** are often very vivid.
□ I am **unable to sleep in a flat** position because of shortness of breath.	□ **While asleep, I have hit or been violent** towards a bed partner or **have injured myself** unknowingly.
□ **Dry mouth** in morning	
□ **Excessive sweating** at night	
□ I usually have a bitter or sour taste in my mouth when I awaken at night or in the morning.	
□ I sometimes wake up with **heartburn.**	
□ I **grind my teeth** when I sleep.	
□ I urinate frequently at night	
□ Attention/concentration problems	
□ Do you have headaches in the morning	

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SLEEP HABITS: (Note: "night" refers to the time of day of your main sleep period)

On weekdays (workdays) I usually go to bed at: _____:_____ (AM or PM)

On weekdays I wake up at: _____:_____ (AM or PM)

On weekends (days off) I go to bed at: _____:_____ (AM or PM)

On weekends, I wake up at: _____:_____ (AM or PM)

The amount of time that I usually take to fall asleep is: _____

The number of times that I usually wake up during the night is: _____

If I wake up during the night, the amount of time it usually takes me to fall asleep again is: _____

How many days a week do you take naps? _____ How long do these naps usually last? _____

Epworth Sleepiness Scale (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you would doze or fall asleep in that situation.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

Use this 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
It is important that you circle a number (0 to 3) on each of the questions.

Situation	**Chance of dozing (0 to 3)**			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place--for example, a theater or meeting	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
In a car while stopped in traffic	0	1	2	3

Safety and Sleepiness: I understand that I am being evaluated for a sleep disorder that is frequently associated with sleepiness during the daytime. The risks of driving and or operating heavy machinery have been explained to me. I have had the opportunity to ask questions of the sleep physician regarding driving and sleepiness.

Date Completed: _____