MUNSON MEDICAL CENTER
Sleep Disorders Center
MUNSON HEALTHCARE

Name: _____ DOB: _____ Date: _____

Please complete this questionnaire and bring with you

Describe your sleep concerns

_____

_____

How long have you had sleep problems:

_____

Do you have trouble falling asleep:
YES NO: Daily 1-2x/week 3-5x/week

Staying asleep:
YES NO: 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_____

Are you told that you snore? YES NO

Are you told that you stop breathing during sleep?
YES NO

Where do you normally sleep:
Bed Recliner Adjustable bed Other:_____

What time do you:
go to bed_____ fall asleep_____
get up_____ days off _____

What is your occupation_____

What hours do you work_____

Do you feel refreshed when you wake up?
YES NO

Do you wake up with headaches? YES NO
1-2x/week 3-5x/week Daily

During sleep do you experience:

Heart Palpitations YES NO
Indigestion or Reflux YES NO
Nasal congestion YES NO
Teeth grinding YES NO
If so, do you wear a bite splint: YES NO

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: YES NO

Do you experience Depression or Anxiety:
YES NO

Have you become increasingly irritable or short tempered: YES NO

Do you feel tired or sleepy during the day:
YES NO: time of day: _____

Do you take NAPS during the day: YES NO
Daily 1-2x/week 3-5x/week

How long are your naps _____

Are they refreshing YES NO

Do you fall asleep at work or at meetings:
Never Rarely 3-5x/week Daily

Do you sleep walk, sleep eat, or sleep talk:
YES NO How often:_____

Do you have nightmares, or night terrors:
YES NO How often:_____

Do you experience symptoms of Restless Leg Syndrome: 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

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

(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

YES NO

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:

YES NO

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

YES NO: ___X's/year ___X's/month Daily

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

Name: _____ DOB: _____ Date: _____

MEDICAL PROBLEMS: PLEASE CIRCLE

High Blood Pressure High Cholesterol Diabetes
Atrial Fibrillation Stroke Anemia Arthritis
Nasal Allergies Asthma Hypothyroidism
Seizures Heart Murmur Melanoma COPD
Depression/Anxiety Bipolar Depression
Gastric Reflux Back Pain Peripheral Neuropathy
Heart Attack When?_____ Fibromyalgia
Compulsive Disorders Malignant Melanoma
Skin cancer? Cell type _____
Other:_____

PAST SURGERIES: PLEASE CIRCLE

Tonsillectomy/Adenoidectomy Uvuloplasty
Sinus Surgery Deviated Septum Repair
Arthroscopy Back Surgery Gall Bladder
Thyroidectomy Appendectomy Coronary
Artery Bypass When _____ Stents When
_____ Hernia Repair Joint Replacement If
yes, which joints? _____
Carpal Tunnel Hysterectomy Ovaries Removed
Uterine Bleeding Removal of skin cancers which
cell type?
Other:_____

PLEASE LIST (OR ATTACH) YOUR MEDICATIONS Doses/Times

Please bring a list of medications and allergies with you take when you see us in the sleep clinic. (include over the counter and herbal meds)

_____
_____
_____
_____

Do you have Medication allergies? NO YES:

_____

Do you smoke: YES NO

____ 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) _____

What is your weight now _____

wt. 5 yrs. ago _____ wt. 10 yrs. ago _____

Marital Status: _____

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
Score 0 – No chance, 1 = slight chance of dosing
2 = moderate chance of dozing 3 = high chance of dozing

Situation	Chance of Dozing
1. Sitting and Reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (church)	_____
4. As a passenger in a car for 1 hour	_____
5. Lying down to rest in the afternoon	_____
6. Sitting and talking with someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. Driving a car, stopped for a few minutes in traffic	_____
Total	_____

If you score 10 or greater you are sleepy

STOP-BANG Score

Snoring: Do you snore loudly (loud enough to be heard through closed doors)?
____ Yes ____ No

Tired: Do you often feel tired, fatigued, or sleepy during daytime?
____ Yes ____ No

Observed: Has anyone observed you stop breathing during your sleep?
____ Yes ____ No

Blood pressure: Do you have or are you being treated for high blood pressure
____ Yes ____ No

BMI: BMI more than 35 kg/m2?
____ Yes ____ No

Age: Age over 50 yrs. old?
____ Yes ____ No

Neck circumference: Neck circumference 40 cm (15-3/4 in.)?
____ Yes ____ No

Gender: Male?
____ Yes ____ No

Total _____/8