McLAREN FLINT
SLEEP DIAGNOSTIC CENTER
Beech-Hill Centre · G-3200 Beecher Road, Suite zzz · Flint, MI 48532 · (810) 342-3900

PATIENT ASSESSMENT

Please complete the following questionnaire and return as soon as possible in the enclosed envelope.

Call if you have any questions (810) 342-3900.

Today's Date: _____ Usual Bedtime:_____

Name: _____ Date of Birth: _____

Best time of day and number to reach you: _____ AM/PM Phone #: _____

Current Weight:_____ Height: _____ Sex: ☐ Male ☐ Female

"X" OR CIRCLE THE CORRECT ANSWER OR WRITE REQUESTED INFORMATION

1. Describe the sleep or wake problem that concerns you.

_____

_____

_____

*Do any other members of your family have sleep problems? If yes, explain.

_____

_____

2. How long have you had this problem? _____

3. Have you had a sleep evaluation or study before this? ☐ Yes ☐ No

3a. When? _____

3b. What kind? _____

3c. Where?_____

3d. Treatment? _____

3f. Are you currently using it? ☐ Yes ☐ No

3g. How many night(s) per week:_____

680b

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4. What is your occupation? _____

Do you work rotating shifts? ☐ Yes ☐ No Third Shift? ☐ Yes ☐ No

5. What time do you usually go to bed? Weekdays: _____ AM / PM

Weekends: _____ AM / PM

6. What time do yo usually get up? Weekdays: _____ AM / PM

Weekends: _____ AM / PM

7. How long does it take you to fall asleep at night? _____ minutes

8. Do you awake during your sleep? ☐ Yes ☐ No

If yes, do you know why you awaken? _____

How long does it take you to get back to sleep?_____ minutes

9. How long altogether are you awake during your night's sleep time? _____ minutes

10. What is the total number of hours of sleep that you usually get at night? _____ hours
(do not include time that you spend awake in bed)

Describe how you feel when you get up: _____

_____

11. Do you ever continue sleep in spite of your alarm sounding? ☐ Yes ☐ No

	Never	***Occasionally***	***Often***
12. Do you snore?	☐	☐	☐
13. Have you been told you stop breathing in your sleep?	☐	☐	☐
14. Do you gag, choke, or cough during sleep?	☐	☐	☐
15. Do you ever feel short of breath during sleep?	☐	☐	☐

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	Never	*Occasionally*	*Often*
16. Do you have a headache when you awaken?	☐	☐	☐
17. Do you have nasal stuffiness or congestion during sleep?	☐	☐	☐
18. Are you sleepy during the day?	☐	☐	☐
19. Are you sleepy when driving?	☐	☐	☐
20. Are you restless during sleep?	☐	☐	☐
21. Do you or have you been told that you frequently kick your legs during sleep?	☐	☐	☐
22. Do you experience restless legs *(crawling or aching feelings, and inability to keep legs still)?*	☐	☐	☐

If you answered "occasionally" or "often", please answer the following as well:

Are your symptoms worse at rest?	☐ Yes	☐ No
Do your symptoms improve by moving?	☐ Yes	☐ No
Are your symptoms worse during the evening?	☐ Yes	☐ No

23. Do you experience vivid, dream-like scenes even though you think that you are awake?	☐	☐	☐
24. Do you fall asleep unintentionally?	☐	☐	☐
25. Do you have weak knees or episodes of muscular weakness *(paralysis or inability to move)* when laughing, angry, or in other emotional situations?	☐	☐	☐
26. Do you wake feeling unable to move *(paralyzed)* when awaking?	☐	☐	☐
27. Do you experience any kind of pain or physical discomfort?	☐	☐	☐

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	Never	*Occasionally*	*Often*
28. Do you have persistent, repeating or violent dreams?	☐	☐	☐
29. Have you ever acted out your dreams or woke up doing so?	☐	☐	☐
30. Do you walk in your sleep?	☐	☐	☐
31. Do you awaken from sleep screaming, violent and confused?	☐	☐	☐
32. Have you ever had seizures or epilepsy?	☐	☐	☐
32a. When? _____			
33. Have you been told that you grind your teeth while asleep?	☐	☐	☐
34. Do you have a sour or acid taste in your mouth during sleep?	☐	☐	☐
35. Do you have heartburn or chest pain during sleep?	☐	☐	☐
36. IS YOUR SLEEP DISTURBED DURING THE NIGHT BECAUSE OF?			
36a. Having thoughts racing through your mind?	☐	☐	☐
36b. Feeling sad and depressed?	☐	☐	☐
36c. Anxiety (worry about things)?	☐	☐	☐
36d. Do you have a fear of not being able to sleep once you have awakened during the night?	☐	☐	☐
37. How much of a problem do you have with FATIGUE *(tiredness, exhaustion, lethargy)* even when you are NOT sleepy?	☐	☐	☐

38. Do you feel you have a sexual concern? ☐ Yes ☐ No

39. How MUCH stress do you have at the present time? ☐ Not Much ☐ Some ☐ A Lot

40. Are you claustrophobic? ☐ Yes ☐ No

40a. If yes, please explain: _____

_____

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41. Please describe your medical history:

			Explain
Hypertension	☐ Yes	☐ No	_____
Heart Problems	☐ Yes	☐ No	_____
Lung Problems	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____
Thyroid Problems	☐ Yes	☐ No	_____
Stroke or other neurological Problems	☐ Yes	☐ No	_____
Sinus or nose problems	☐ Yes	☐ No	_____
Heart burn	☐ Yes	☐ No	_____
Depression	☐ Yes	☐ No	_____
Hallucinations	☐ Yes	☐ No	_____
Mood swings	☐ Yes	☐ No	_____
Arthritis	☐ Yes	☐ No	_____
Chronic pain	☐ Yes	☐ No	_____
Allergies	☐ Yes	☐ No	_____

42. List surgeries: _____

_____

_____

_____

43. Are you now or have ever been under the care of a Psychiatrist or other mental health professional? ☐ Yes ☐ No

If so, who? _____ when? _____

What treatment did you receive? *(ie. medication, counseling)*:

_____

_____

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44. Do you take any prescribed medication?

Name:	*Amount:*	*How Often:*	*Reason:*

45. Do you smoke or have you smoked? ☐ Yes ☐ No

45a. If Yes, how long have you or did you smoke? _____

45b. How many packs per day? _____

45c. When did you quit? _____

46. Do you drink alcohol? ☐ Yes ☐ No

46a. How much per week? _____

47. Do you use recreational drugs? ☐ Yes ☐ No

47a. Which ones? _____

48. Do you use caffeinated beverages? ☐ Yes ☐ No

What type? _____

How much per day? _____

Time of last cup or glass? _____

49. Regarding drownsiness rather than just fatigue, enter the number that corresponds to how likely drowsiness is to occur to you in the following situation:

0 = NEVER OCCURS

1 = OCCASIONALLY OCCURS
(less than 50% of the time)

2 = OFTEN OCCURS
(50% of the time)

3 = USUALLY OCCURS
(more than 50% of the time)

_____ **A.** Sitting and Reading

_____ **B.** Watching TV

_____ **C.** At a public place like a theater or meeting

_____ **D.** While a passenger in a car riding for one hour

_____ **E.** Lying down in the afternoon

_____ **F.** Sitting and talking to someone

_____ **G.** Sitting down after lunch

_____ **H.** While driving a car and stopped at a traffic light

_____ **Total**

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THIS PAGE IS TO BE COMPLETED BY YOUR BEDPARTNER, IF APPLICABLE.

We often find that the information provided by the patient's bedpartner can be vital in assisting in the diagnosis of sleep disorders. Your cooperation is greatly appreciated.

	Never	*Occasionally*	*Often*
1. Snore?	☐	☐	☐
2. Snore loudly enough to disturb your sleep?	☐	☐	☐
3. Stop breathing during his/her sleep?	☐	☐	☐
4. Gasp for breath, cough, choke?	☐	☐	☐
5. Kick during sleep?	☐	☐	☐
6. Fall alseep before going to bed?	☐	☐	☐
7. Start to doze off while driving?	☐	☐	☐
8. Appear sleepy during the day?	☐	☐	☐
9. Toss and turn while sleeping?	☐	☐	☐
10. Act out his/her dreams?	☐	☐	☐
11. Talk in his/her sleep?	☐	☐	☐
12. Walk in his/her sleep?	☐	☐	☐
13. Get out of bed during the night?	☐	☐	☐

14. Have you noticed any personality changes? _____

_____

_____

_____

15. Please use the space below to report any information you believe to be pertinent. _____

_____

_____

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