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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MR.#/P.M.

DR.

	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

	Never	Occasionally	Often
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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DR.

	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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PATIENT ASSESSMENT

41. Please describe your medical history: ***Explain***

Condition	Yes	No	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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