

Mercy Clinic South Sleep Questionnaire

Please complete before your visit so we can use your time with us wisely.

Date of visit: _____ Time: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ years old Sex: Male Female

Name of Referring Physician: _____

Name of Primary Care Physician: _____

MEASUREMENTS

How tall are you? _____ feet _____ inches What did you weigh 5 years ago? _____

What did you weigh 1 year ago? _____ What do you weigh now? _____

What is your neck/collar size? _____ in/cm

PRESENT CONDITION

What are the reasons you are consulting a Sleep Physician? _____

Chief or most bothersome complaint: _____

MEDICAL HISTORY

What medical problems, conditions, or illnesses have you had before or now? Check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Anemia or low iron | <input type="checkbox"/> Kidney disease or Kidney Stones |
| <input type="checkbox"/> COPD (Chronic Bronchitis or Emphysema/Asthma) | <input type="checkbox"/> Muscle or Joint problems |
| <input type="checkbox"/> Dementia or memory problems | <input type="checkbox"/> Neuropathy (numbness/tingling in hands/feet) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Parkinson's Disease or Tremors |
| <input type="checkbox"/> GERD (Gastroesophageal Reflux Disease) | <input type="checkbox"/> Pulmonary Hypertension |
| <input type="checkbox"/> Hay Fever (Allergic Rhinitis)/Seasonal Allergies | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Headaches or Migraine | <input type="checkbox"/> Stroke or TIA (Cerebrovascular Disease) |
| <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> High Blood Pressure (Hypertension) | <input type="checkbox"/> Male or Female Hormone Problems |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Females: Age of Menopause onset? _____ |

Other: _____

MENTAL CONDITIONS/DISORDERS

Have you ever experienced any of the following mental conditions/disorders? Check all that apply.

- Anxiety/Panic Disorder
- Attention Deficit Hyperactivity Disorder (ADHD)
- Bipolar Disorder
- Dementia
- Depression
- Nervous Breakdown
- Obsessive Compulsive Disorder (OCD)
- Post-Traumatic Stress Disorder (PTSD)
- Schizophrenia
- Suicide attempt
- Mood Swings
- Other: _____

SURGERY

What surgical procedures have you undergone? Check all that apply.

- Bariatric Surgery
- Tonsillectomy/Adenoidectomy
- Mouth or Facial Surgery, specify: _____
- Other, specify: _____
- Cleft Palate Repair
- Nasal Trauma or Surgery

ALLERGIES

Are you allergic to latex? yes no

Do you have any food allergies? yes no If yes, list: _____

Do you have allergies to medication? yes no If yes, list: _____

FAMILY HISTORY

Please indicate medical problems, conditions, or illnesses that your immediate family suffer

	Father	Mother	Brother 1	Brother 2	Sister 1	Sister 2	Children
Is family Member alive?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety							
Depression							
Bedwetting							
Narcolepsy							
Obstructive Sleep Apnea							
Periodic Limb Movements							
Sleep Terrors							
Sleep Walking							
Insomnia							

Other: _____

SUBSTANCE USE

Do you drink alcoholic beverages? Never Yes Former drinker, year quit _____

What kinds? _____ How much? _____ servings per, day week month year

Do you drink caffeine? Coffee: No Yes _____ cup(s) per, day week month year
Tea: No Yes _____ cup(s) per, day week month year
Soda: No Yes _____ cup(s) per, day week month year
Energy Drinks: No Yes _____ cup(s) per, day week month year

What time do you drink your last cup of coffee, tea, soda, energy drink? _____

Have you ever used any tobacco products? No Yes

If Yes: Cigarettes (___pack(s) per ___) Cigars (___stick(s) per ___) Pipe (___bowl(s) per ___)

How old were you when you started smoking? _____ If you have quit, when did you quit? _____

Have you ever used any recreational drugs? Never Yes Former use, quit in _____

Check all that apply and specify how much:

- Cocaine _____ day week month Methamphetamine _____ day week month
- Ecstasy _____ day week month Morphine _____ day week month
- Heroin _____ day week month PCP _____ day week month
- Marijuana _____ day week month Other, specify: _____

EXERCISE

Do you exercise? No Yes Type of exercise: _____

How long do you exercise? _____ hours _____ minutes How often? _____ time(s) per week

EMPLOYMENT

Job/Occupation: _____ Retired Disabled

Do you do any shift work? No Yes How often does your shift change? _____

Fill in the start time and end time for each day of your current work schedule below:

Shift 1 Day	Start Time	End Time	Shift 2 Day	Start Time	End Time	Shift 3 Day	Start Time	End Time
Monday			Monday			Monday		
Tuesday			Tuesday			Tuesday		
Wednesday			Wednesday			Wednesday		
Thursday			Thursday			Thursday		
Friday			Friday			Friday		
Saturday			Saturday			Saturday		
Sunday			Sunday			Sunday		

SLEEP SCHEDULE

Fill in your sleep schedule below	Workdays	Days off/Weekends
What time do you go to bed?		
How long does it take you to fall asleep?		
How many times do you wake up during your sleep?		
What is the reason for waking up?		
How long does it take you to fall back asleep after awakening?		
What time do you wake up at the end of your sleep period?		
Do you use an alarm to wake up?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What time do you get out of bed?		
Do you nap?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What time do you start your nap?		
What time do you end your nap?		

SLEEP PATTERNS

Upon waking up in the morning, how do you feel? Check all that apply.

- Refreshed Sleepy/Tired Muscle/Joint aches and pains Dry mouth/throat
- Morning headaches, how long does the headache last? _____ hours _____ minutes

Has anyone ever seen you stop or pause breathing when you sleep or nap? Yes No

Have you ever awakened yourself due to snoring? Yes No

Do you snore or has anyone ever told you that you snore? Yes No

- Describe how loud you snore:
- faint
 - heard only inside my bedroom
 - heard outside bedroom with door open
 - heard outside bedroom with door closed

ARM/LEG SENSATIONS

Do you have irresistible or uncontrollable urge to move your legs, arms, Etc?

Do you experience any uncomfortable sensations in your arms or legs?

- Calf Thigh Foot Arms Other _____

Which of the following phrases best describes your arm/leg sensations? Check all that apply.

- Creepy/Crawly Crampy (Charlie Horse) Discomfort/Achy Sharp/Shooting Sensation
- Pins and Needles Other: _____

What time do the leg sensations occur? Check all that apply.

- Morning Early Afternoon Late Afternoon Evening Night

Which of the following maneuvers help relieve your leg sensations? Check all that apply.

Walking Rubbing/Massaging Stretching Other: _____

Have you ever been told your legs move a lot when you sleep? Yes No

DRIVING

Do you feel sleepy when driving? Yes No

Ever had a car accident due to sleepiness? Yes No

SYMPTOMS

Do you Experience any of the following symptoms?

- Sudden loss of muscle tone of body or body parts (knees, neck, jaw, etc.) while laughing, telling a joke, or experiencing intense emotion.
- Inability to move your entire body upon waking up, as if you were paralyzed even for a few seconds.
- See visual images or hear voices that are not supposed to be there, upon falling asleep or waking up.
- Talk in your sleep.
- Walk in your sleep.
- Eat in your sleep.
- Wake up in the middle of the night to eat.
- Wake up confused, screaming, yelling.
- Have trouble waking up and getting out of bed in the morning.
- Grind your teeth at night.
- Act out your dreams (punching, kicking, fighting, etc.)
- Nightmares.
- Wheezing that wakes you up at night.
- Coughing that wakes you up at night.
- Shortness of breath at night.
- Choking while sleeping at night.
- Chest pains at night.
- Leg cramps at night.
- Frequent urination during the night.

ADDITIONAL INFORMATION

Is there any general information about your health; or specific information about your main problem that you feel your physician should know?
