Mercy Clinic South Sleep Questionnaire

Please complete before your visit so we can user 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 is your neck/collar size? _____in/cm

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

PRESENT CONDITION

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

Chief or most bothersome complaint: _____

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?	□ Yes □ No	□ Yes □ No
What time do you get out of bed?		
Do you nap?	□ Yes □ No	□ Yes □ 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

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.

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

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		

MEDICAL HISTORY

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

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

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? _____

Do you use any tobacco products? □ No □ Yes

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

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

Do you use recreational drugs? □ Never □ Yes □ Former use, quit in _____

Check all that apply and specify how much:

□ Cocaine _____ □ day □ week □ month
□ Ecstasy _____ □ day □ week □ month
□ Heroin _____ □ day □ week □ month
□ Marijuana _____□ day □ week □ month
□ Methamphetamine _____ □ day □ week □ month
□ Morphine _____ □ day □ week □ month
□ PCP _____ □ 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

SURGERY

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

□ Bariatric Surgery
□ Tonsillectomy/Adenoidectomy
□ Mouth or Facial Surgery, 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?	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
Anxiety							
Depression							
Bedwetting							
Narcolepsy							
Obstructive Sleep Apnea							
Periodic Limb Movements							
Sleep Terrors							
Sleep Walking							
Insomnia							

Other: _____

ADDITIONAL INFORMATION

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

_____

_____

_____

_____