MICHIGAN MEDICINE Sleep Disorders Center **Health History Questionnaire—New Patient—**	NAME: MRN: BIRTHDATE:

Date of appointment: ____/____/____(*mm/dd/yyyy*)

PLEASE FILL THIS FORM OUT AS COMPLETELY AS POSSIBLE

Do you currently use a CPAP machine? ☐Yes ☐No

If yes, do you have a data card? ☐Yes ☐No

If yes, please bring your data/smart card with you to your appointment.

REASON FOR VISIT: ____

HOW OFTEN DO YOU OR OTHERS NOTICE THE FOLLOWING? (PLEASE √)

	Never	**Rarely** (once a month or less)	**Some** (once a week)	**Often** (2-4 times a week)	**Almost Always**
Snoring					
Breathing pauses when you sleep					
Wake up choking or gasping					
Wake up with shortness of breath					
Wake up with dry mouth/sore throat					
Nasal/sinus congestion					
Morning headaches					
Wake to urinate 2 or more times a night					
Heartburn interfering with sleep					
Grind teeth while sleeping					
Nightmares					
Sleep walking					
Sleep talking					
Acting out dreams					
Restless or discomfort in legs					
If yes, is this worse at night? ☐Yes ☐No					
If yes, is this relieved by movement? ☐Yes ☐No					
Kicking/jerking of legs while sleeping					
Hallucinations when falling asleep/waking up					
Momentary complete paralysis when falling asleep or upon awakening					
While awake, do you have episodes of muscle weakness brought on by strong emotions					

How would you rank the intensity of your snoring on a scale of 0 to 4?	0 none	1 soft	2 moderate	3 loud	4 severe

The following refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Check (√) the most appropriate response for each situation.

How likely are you to doze off or fall asleep (not just feel tired) in the following situations?

	No Chance	Slight Chance	Moderate Chance	High Chance
Sitting and reading				
Watching TV				
Sitting inactive in a public place (like a theatre or a meeting)				
Riding as a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes in traffic				
At the dinner table				
While driving				

Previous Sleep Evaluation(s)

1. Have you been evaluated in a sleep clinic previously? ☐Yes ☐No

2. Have you had a sleep study? ☐Yes ☐No

3. What was your diagnosis: ____

(If you previously had polysomnograms (Sleep Studies), please bring them with you to your appointment. Contact the Sleep Disorders Center 734-936-9068 if you need assistance obtaining the studies).

4. Have you had surgery for either snoring or sleep apnea? ☐Yes ☐No

   A. If yes, list type, dates, and location: ______________________________________

Sleep Habits

1. What time do you generally go to bed? During the week _________Weekend/days off____________

2. What time do you get out of bed in the morning? During the week _________Weekend/days off____________

3. How long does it usually take you to fall asleep? ___________________

4. How many times do you wake up during a typical night? __________________

5. What wakes you up at night? _________________________________

6. Do you nap intentionally? ☐Yes ☐No

   A. If yes, how many days per week? ______ For how long? _____________

   B. Do you feel refreshed upon awakening from the nap? ☐Yes ☐No

7. Have you taken any prescription medications/over-the-counter medications/herbal supplements:

…to help you sleep? ☐Yes ☐No

…to keep you awake? ☐Yes ☐No

If YES, please list sleep/wake promoting medication, dates taken and effectiveness (includes over the counter and prescription medications).

MEDICATION	DATES	ELABORATE ON EFFECTIVENESS

Allergies: ☐Yes ☐NoIf yes, please list: *(example: Penicillin: Hives)*

ALLERGY	WHAT HAPPENED?
1.	
2.	
3.	

Past Medical History (Please check any medical problems that you have had in the past)

☐Insomnia
☐Restless Leg Syndrome
☐Anxiety
☐Arthritis
☐Bipolar disorder
☐Borderline personality disorder
☐Cancer
☐Clotting disorder
☐Congestive heart failure
☐Coronary artery disease
☐Dementia
☐Depression
☐Narcolepsy
☐Obstructive Sleep Apnea
☐Developmental delay
☐Diabetes mellitus
☐Emphysema
☐Glaucoma
☐Headaches
☐Hearing loss
☐Heart murmur
☐HIV/AIDS
☐Hypertension
☐Kidney disease
☐Liver disease
☐Memory loss
☐Movement disorder
☐Schizophrenia
☐Seizures
☐Syncope (fainting)
☐Thyroid disease
☐Ulcers
☐Vision problems

☐Other ____

Past Surgical History (Check any surgeries you have had and the date of surgery if you know it)

☐Deviated nasal septum repair	☐Tonsils removed	☐Adenoids removed	☐UPPP
☐AVM surgery	☐Epilepsy surgery	☐Lung transplant	
☐Back surgery	☐Eye surgery	☐Spinal fusion cervical	
☐Brain surgery	☐Heart surgery	☐Spinal fusion lumbar	
☐Brain biopsy	☐Heart transplant	☐Spine surgery	
☐Cardiac catheterization	☐Intracranial aneurysm	☐Vagus nerve stimulation	
☐Carotid endarterectomy	☐Kidney transplant	☐Valve replacement	
☐Craniotomy	☐Laminectomy	☐VP shunt placement	
☐Deep brain stimulation	☐Liver transplant	☐Other __________________________	

Family History

☐I was adopted so I do not know my family history.

Check below to report problems your family members have had. Please state the age when they had the problem if you know it.

	Mother	Father	Sister	Brother	Daughter	Son	Other (list)
Insomnia							
Narcolepsy/Cataplexy							
Obstructive Sleep Apnea							
Restless Legs Syndrome							
Cancer							
Depression							
Diabetes							
Epilepsy							
Heart disease							
Hypertension							
Migraines							
Movement disorder							
Neuropathy							
Parkinsonism							
Seizures							
Stroke							
Other (list below)							

Social History

1. Do you ever drink **alcohol**? ☐Yes ☐No

If yes, please indicate the quantity **per week** of each:

- Glasses of wine _____
- Cans/bottles of beer _____
- Shots of liquor _____
- Drinks containing 0.5 oz. of alcohol _____

2. Do you use recreational **drugs**? ☐Yes ☐No

- If you use drugs, how many times **per week**? _________________
- What type(s) of drugs do you use?
  ____

3. How many **caffeine**-containing beverages do you consume **per day**? ________________

Marital Status	Children	Work Status
☐ Single	☐ None	☐ Full time employment
☐ Married	☐ Yes, but not living with me	☐ Part time employment
☐ Widowed	☐ Yes, living with me	☐ Retired
☐ Divorced		☐ Unemployed
☐ Domestic Partner		☐ Self-Employed
		☐ Disabled
		☐ Student

Occupation (Brief Description) ____

Highest level of education completed: ____

Does your partner sleep in the same room? ☐Yes ☐No

If yes, is/are your partner(s): ☐Male ☐Female

REVIEW OF SYSTEMS

*Please check **ONLY new symptoms** that your other doctors are not aware of:*

NEUROLOGICAL	GASTROINTESTINAL	MUSCULOSKELTAL/SKIN	EYES
☐ Headaches	☐ Difficulty Swallowing	☐ Joint Pain/Swelling	☐ Visual changes
☐ Dizzy Spells	☐ Nausea/Vomiting	☐ Muscle Pain	☐ Eye pain
☐ Seizures	☐ Diarrhea	☐ Back Pain	**ENDOCRINE**
☐ Fainting	☐ Constipation	☐ Neck Pain	☐ Excessive thirst
☐ Memory Loss	☐ Bloody or Black Stool	☐ Rash	☐ Heat/Cold intolerance
☐ Numbness/Tingling	☐ Abdominal pain		☐ Hot flashes
☐ Weakness	☐ Heartburn		
	☐ Vomiting Blood		

b

HEART	EAR/NOSE/THROAT	KIDNEY/BLADDER	ALLERGY/IMMUNOLOGY
☐ Chest Pain ☐ Palpitations ☐ Swelling of feet	☐ Hearing Loss ☐ Ear aches ☐ Sinus Pain ☐ TMJ pain or clicking ☐ Nasal congestion ☐ Nasal drainage ☐ Nasal Polyps ☐ Nose bleeds ☐ Mouth sores ☐ Hoarseness	☐ Urinate Frequently ☐ Urination problems ☐ Sexual Difficulty	☐ Seasonal Allergies ☐ Eczema
LUNGS		**GENERAL**	**BLOOD**
☐ Shortness of breath ☐ Coughing ☐ Coughing up blood ☐ Wheezing		☐ Fever ☐ Night sweats ☐ Loss of appetite ☐ Unexpected weight loss ☐ Weight gain	☐ Anemia ☐ Easy bruising/bleeding
			PSYCHIATRIC
			☐ Anxiety/Nervousness ☐ Depression/Sadness