RESET

NOVI SLEEP & DIAGNOSTIC CENTER

Sleep Questionnaire

Patient's Name:			Referring Dr.:		
Today's Date:	DOB:		Age:	Marital Status:	Gender:
Occupation:			Phone:		Height:
Current Weight:	Weight 1 year ago:	Weight 5 years ago:	10 yrs ago:	15 yrs ago:	20 yrs ago:

What is your main sleep related problem and duration:

_____

_____

_____

_____

SLEEP SCHEDULE (*please provide the following information and circle the answer where appropriate*)

What time do you go to bed on WEEKDAYS? _____ WEEKENDS? _____

What time do you wake up on WEEKDAYS? _____ WEEKENDS? _____

Do you **nap**? ◯ YES ◯ NO

How **often** do you **nap**? _____ Times per week

How **long** are the **naps**? _____ Minutes

Do you **awaken refreshed**? ◯ YES ◯ NO

Are you a **shift worker**? ◯ YES ◯ NO If yes, what times do you work? _____

SNORING/ BREATHING HISTORY (*please circle appropriate answer*)

Do you have a CPAP/BiPAP Machine? ◯ YES ◯ NO

Do you have any of the following symptoms:

Do you **snore**? ◯ DON'T KNOW ◯ SOMETIMES ◯ YES ◯ NO

Does your **sleep position** affect your **snoring**? ◯ YES ◯ NO

Have you awakened **choking** or short of **breath**? ◯ YES ◯ NO

Has anyone noticed that you **stop breathing** while asleep? ◯ YES ◯ NO

Do you have morning **headaches**? ◯ YES ◯ NO

Do you awaken more than twice to **urinate** during the night? ◯ YES ◯ NO

Do you awaken **refreshed** in the morning? ◯ YES ◯ NO

Do you awaken with an **acid or sour taste** in your mouth? ◯ YES ◯ NO

Do you have difficulty sleeping on your back? ◯ YES ◯ NO

NAME: _____ DOB: _____

SLEEP HISTORY (*please circle appropriate answer)*

Do you have **difficulty falling asleep**? YES NO

Do you have **difficulty staying asleep**? YES NO

Do you **wake up too early** and cannot get back to sleep YES NO

Do you have thoughts **racing through** you mind that make it difficult to sleep? YES NO

Have you fallen **asleep unexpectedly**? YES NO

Have you ever fallen **asleep** while **driving drowsy**? YES NO

Have you ever had a motor **vehicular crash** due to **drowsy driving**? YES NO

Have you experienced **"sleep attacks"** (a sudden irresistible urge to sleep?) YES NO

Have you experienced **sudden muscle weakness** in response to emotions? YES NO

Have you experienced **an inability to move while falling asleep** or waking up? YES NO

Have you experienced **dreamlike images** or sounds while falling asleep or waking up? YES NO

Do you **kick or jerk** your arms or legs during sleep? YES NO

Have you experienced an **urge to move** your legs accompanied by an **uncomfortable** sensation? YES NO

Do you have an urge to move your **legs** that **worsens with rest or inactivity** like lying Down or sitting? YES NO

Do you have an urge to move your **legs** that is **relieved by walking or stretching**? YES NO

Do you have an urge to move and unpleasant sensation **in legs** that occurs **only at night**? YES NO

Do you **talk** in your sleep YES NO

Do you have **nightmares**? YES NO

Have you ever **acted out** your **dreams**? YES NO

Do you **grind** your teeth? YES NO

MEDICAL/SURGICAL HISTORY (please circle answer and fill in the blank where appropriate)

Do you use home oxygen? YES NO What liter/flow setting? _____

Do you have a pacemaker/defibrillator with pacemaker (*circle which one*) YES NO

Have you ever had a tonsillectomy? YES NO

Have you ever had sinus or nasal surgery YES NO

Have you ever broken your nose? YES NO

Have you ever had any type of head injury? YES NO

Have you had surgery to promote weight loss? YES NO When? _____

NAME: _____ **DOB:** _____

Please circle if you have a history of any of the following health problems.

☐ Hypertension	☐ Acid Reflux (heartburn)	☐ Dementia
☐ Heart Attack	☐ Arthritis	☐ Memory Problems
☐ Congestive Heart Failure	☐ Fibromyalgia	☐ Claustrophobia
☐ Cardiac Arrhythmias	☐ Sexual dysfunction/loss of libido	☐ Thyroid Problems
☐ Diabetes	☐ Depression	
☐ Lung problems/COPD/Asthma	☐ Anxiety	
☐ Stroke/TIA	☐ Seizures	

Other _____

FAMILY HISTORY (*does any member of your family have the following)*

Sleep Apnea? ◯ YES ◯ NO Relationship _____
Narcolepsy? ◯ YES ◯ NO Relationship _____
Seizure disorder? ◯ YES ◯ NO Relationship _____
Depression? ◯ YES ◯ NO Relationship _____
Hypertension? ◯ YES ◯ NO Relationship _____
Stroke? ◯ YES ◯ NO Relationship _____
Heart Disease? ◯ YES ◯ NO Relationship _____
Psychiatric illness? ◯ YES ◯ NO Relationship _____
Other Disorder _____ Relationship _____

MEDICATIONS (please list, attach a separate sheet if necessary)

Medication	Dose	# Times/Day	Medication	Dose	# Times/Day

Do you have any drug allergies? (*Please list)*

_____

_____

Do you have any environmental allergies? (*Please list)*

_____

_____

Do you have any food allergies? _____

Have you had a current flu vaccine? ◯ YES ◯ NO When? _____

Have you had a current pneumonia vaccine? ◯ YES ◯ NO When? _____

NAME: _____ **DOB:** _____

SURGERIES **DATE**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

REVIEW OF SYSTEMS

(*please check where appropriate if you have had any of these symptoms in the last 12 months)*

_____ Frequent headaches
_____ Fainting or passing out
_____ Difficulty understanding instructions
_____ Difficulty giving instructions
_____ Difficulty following instructions
_____ Difficulty planning activities/trips
_____ Sudden loss of vision, strength
_____ Hearing loss or ringing in ears
_____ Nosebleeds
_____ Cough for more than 2 weeks
_____ Coughing up blood
_____ Shortness of breath/wheezing
_____ Swelling in feet or ankles
_____ Chest pain or heaviness
_____ Irregular heartbeat
_____ Difficulty swallowing
_____ Abdominal pain
_____Frequent heartburn
_____ Frequent constipation
_____ Difficulty urinating/incontinence
_____ Blood in urine
_____ Urinating more than 2 times a night
_____ Pain in bones or joints
_____ Unusual bruising or bleeding
_____ Convulsions
_____ Change in wart, mole or skin growth
_____ Weight loss of more then 5-10 lbs
_____ Other describe) _____

SOCIAL HISTORY

What is your occupation? _____ If retired, when? _____

Previous jobs held

_____

Do you share a bed with someone? ◯YES NO◯

(If the answer is "YES" please have your bed partner fill out the Bed Partner/Parent Observation Questionnaire)

Are you a lifetime NON smoker? ◯ YES ◯ NO
Do you smoke cigarettes daily? ◯ YES ◯ NO Pack per day? _____ How many years? _____
Do you smoke cigarettes some days? ◯ YES ◯ NO When? _____
If you quit smoking, what year did you quit? _____ Pack per day? _____ How many years? _____

Do you drink beer, wine, or liquor? (*Circle which one)* ◯YES ◯NO How many years? _____

How often:

◯1-2 drinks/day ◯more than 2 drinks/day ◯1-4 drinks/wk. ◯7 drinks/wk.
◯10 drinks/wk. ◯14 drinks/wk. ◯Rarely

Did you quit drinking alcohol? ◯YES ◯NO **If so, When?** _____

NOVI SLEEP & DIAGNOSTIC CENTER

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Please circle the most appropriate answer using the following scale

Patient Name: _____ DOB: _____

0= Never 1= Occasionally 2= Often 3 = Usually	
How likely are you to doze off or fall asleep while sitting and reading?	**0 1 2 3**
How likely are you to doze off or fall asleep while watching television?	**0 1 2 3**
How likely are you to doze off or fall asleep while in a theater or meeting?	**0 1 2 3**
How likely are you to doze off or fall asleep while traveling as a passenger?	**0 1 2 3**
How likely are you to doze off or fall asleep while resting in the afternoon?	**0 1 2 3**
How likely are you to doze off or fall asleep while sitting and talking with someone?	**0 1 2 3**
How likely are you to doze off or fall asleep while sitting quietly after a meal?	**0 1 2 3**
How likely are you to doze off or fall asleep while sitting in a car stopped in traffic?	**0 1 2 3**

Total score out of 24: _____ *(please add)*

Do you feel like your daytime sleepiness can interfere with your daily activities? Yes or No

Signature: _____ Date: _____

(Patient/guardian/caretaker)

Reviewing Technologist: _____ Date: _____

Questionnaire updated & reviewed with patient: _____ Date: _____

NOVI SLEEP & DIAGNOSTIC CENTER

Sleep Log

Patient's Name:	DOB:	Date:

Please fill this form out the *WEEK PRIOR* to your appointment. Bring this completed form with you to the Novi Sleep and Diagnostic Center on your scheduled appointment date.

(MINIMUM OF 2 DAYS IS REQUIRED)

SPECIFY UNDER APPROPRIATE DAY OF THE WEEK TO THE RIGHT.	Example	**MON**	**TUES**	**WED**	**THURS**	**FRI**	**SAT**	**SUN**
TODAY I WENT TO BED AND TURNED THE LIGHTS OFF AT _____.	**11:15 PM**							
AFTER TURNING THE LIGHTS OFF LAST NIGHT, I FELL ASLEEP IN ___ MINUTES.	**40**							
MY SLEEP LAST NIGHT WAS INTERRUPTED __ TIMES. (SPECIFY # OF NIGHTTIME AWAKENINGS)	**3**							
MY SLEEP LAST NIGHT WAS INTERRUPTED FOR ___ MINUTES. (SPECIFY DURATION OF EACH AWAKENING)	**10** **5** **5**							
THIS MORNING, I WOKE UP AT _____ AM/PM. (NOTE TIME OF LAST AWAKENING)	**6:15 AM**							
THIS MORNING, I GOT OUT OF BED AT _____ AM/PM (SPECIFY THE TIME)	**6:40 AM**							
TOTAL # OF HOURS OF SLEEP LAST NIGHT.	**6 HRS**							
WHEN I GOT UP THIS MORNING, I FELT _____. (1 = VERY GOOD, 5 = VERY BAD)	**2**							
OVERALL, MY SLEEP LAST NIGHT WAS _____. (1 = VERY RESTLESS, 5 = VERY SOUND)	**3**							
TODAY, I NAPPED FOR _____ HRS. (NOTE THE TIMES OF ALL NAPS)	**2 HRS**							
TODAY, I TOOK ___ MG OF MEDICATION AND/OR ___ OZ OF ALCOHOL AS A SLEEP AID.	**ASPIRIN 500 MG**							

Bed Partner/Parent Observation Questionnaire

Name of Patient: _____ Date: ___/___/___

Check any of the following behaviors that you have observed the patient doing while asleep

___ loud snoring
___ light snoring
___ twitching of legs or feet during sleep
___ pause in breathing
___ grinding teeth
___ sleep talking
___ sleepwalking
___ bed wetting
___ sitting up in bed but not awake
___ head rocking or banging
___ kicking with legs during sleep
___ getting out of bed but not awake
___ biting tongue
___ becoming very rigid and/or shaking

How long have you been aware of the sleep behaviors(s) that you checked above?

_____

_____

_____

_____

_____

Describe the behavior checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

_____

_____

_____

_____

_____

_____

_____

If you have heard loud snoring, do you remember pauses in the snoring or occasional loud “snorts”?

_____

_____

_____

_____

_____ _____

Signature of Person Completing this Form Relationship