



Michigan Heart Sleep Center

MICHIGAN HEART SLEEP CENTER

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.): _____ M F DOB: _____
Marital status: Single Married Separated Divorced Widowed Other
Race: Black White Hispanic Asian/Pacific Islander Native American/Alaskan Native Other
Previous or referring doctor: _____ Date of last physical exam: _____

ACUTE SLEEP SYMPTOMS

What is your main sleep problem?: _____
How long has this been a problem?: last 3 months last 6 months last year more than 1 yr I don't remember
Is this problem: getting worse getting better staying the same

CLINICAL DATA QUESTIONS

Are you currently taking any blood pressure medications? Yes No If "Yes", how many? 1 2 3 4

Have you ever taken a sleeping pill (prescription or OTC)? Yes No

If yes, what and when: _____

Do you use tobacco? Yes No

Have you ever been diagnosed with the following?:

- Coronary Artery Disease Atrial Fibrillation Pacemaker
- Congestive Heart Failure Diabetes Internal Defibrillator
- Stroke TIA (mini stroke)

PERSONAL HEALTH HISTORY

Allergies: (Please list any food, medication or environmental allergies AND the reaction you had.)

Physical Information: Height: _____ Weight: _____ Neck Size: _____
How would you currently describe your health: Excellent Good Fair Poor Very Poor



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SLEEP HISTORY AND CURRENT SLEEP HABITS

During your sleep, do you currently have or in the last 6 months have had any of the following problems? (Please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Stop breathing in your sleep | <input type="checkbox"/> Frequent arousals from sleep | <input type="checkbox"/> Dry mouth at night |
| <input type="checkbox"/> Difficulty initiating / maintaining sleep | <input type="checkbox"/> Drooling at night | <input type="checkbox"/> Morning headaches |
| <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Morning fatigue | <input type="checkbox"/> Nightmares/Night terrors |
| <input type="checkbox"/> Leg discomfort before falling asleep | <input type="checkbox"/> Leg cramps while asleep | <input type="checkbox"/> Shortness of breath when lying down |
| <input type="checkbox"/> Frequent trips to the bathroom | <input type="checkbox"/> Loud snoring | <input type="checkbox"/> Restless sleeper |
| <input type="checkbox"/> Palpitations at awakening | <input type="checkbox"/> Sleep walking/talking | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Heartburn /gas pains | <input type="checkbox"/> Gasping/Choking sensation | <input type="checkbox"/> Cold extremities |

What is your usual bed time? _____

What is your usual rise time? _____

Have you ever hurt yourself during sleep? Yes No

Have your movements during sleep ever hurt others? Yes No

Have you ever had a sleep study? Yes No

If yes, where and when: _____

Do you sleep alone? Yes No

If no, who sleeps in bed with you: Spouse Significant Other Child/Parent Pet

How would you describe your sleep?: Excellent Good Fair Poor Very Poor

How would you describe your bed partners sleeping?: Excellent Good Fair Poor Very Poor

How regular are your sleep habits?: Very Regular Usually Regular Usually Irregular Very Irregular

How long does it usually take you to fall asleep? 0-10 min 11-20 min 21-30 min 31-60 min more than 60 min

How many times do you wake up during an average night? 0 1 2 3 4 5 more than 5

When you wake up during the night, how long does it usually take you to fall back to sleep?

How long does it usually take you to fall asleep? 0-10 min 11-20 min 21-30 min 31-60 min more than 60 min

If you can't fall back to sleep do you get out of bed? Yes No

Do you watch television or listen to music to help you fall asleep? Yes No

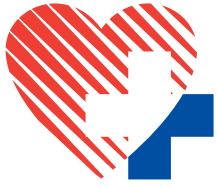
How many hours of sleep do you get each night on the average? 5hrs or less 6 hrs 7 hrs 8 hrs 9 hrs more than 9 hrs

Do you keep the same schedule on weekends or days off work? Yes No

How often is your sleep disrupted by discomfort or pain? 0 1 2 3 4 5 more than 5

Please describe your normal work hours. _____

If you do shift work, how often does your shift change? _____



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HEALTH HABITS AND PERSONAL SAFETY

- Exercise Sedentary (No exercise)
 Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
 Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
 Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

- Diet Are you dieting? Yes No
If yes, are you on a physician prescribed medical diet? Yes No
of meals you eat in an average day? _____

- Caffeine None Coffee Tea Cola
of cups/cans per day? _____

- Alcohol Do you drink alcohol? Yes No
If yes, what kind? _____
How many drinks per week? 1-2 3-4 5-6 7-8 more than 8

- Tobacco Do you use tobacco? Yes No
Cigarettes – pks./day _____ Chew - #/day _____ Pipe - #/day _____ Cigars - #/day _____
of years _____ Or year quit _____

DAYTIME FUNCTIONING

Do you feel FATIGUE (tiredness, exhaustion, lethargy) in the daytime even when you are not sleepy?

- No Infrequently Occasionally Often Always

Do you feel SLEEPY (or struggle to stay awake) in the daytime? No Infrequently Occasionally Often Always

If so under what circumstances do you fall asleep easily? (check all that apply)

- Driving After Meals Meetings/Class/Church Reading/Watching TV Other

Does your daytime sleepiness interfere with: (Please check all that apply) Household Chores Relationships Job Performance School

Have you ever had an accident or near miss from falling asleep while driving? Yes No

How often do you feel alert and energetic for an entire day? Never Sometimes Most of the time All the time

Do you take naps (intentional or unintentional) during the day? Yes No

If so how often and for how long? _____

Do you feel refreshed after naps?: Yes No



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MOOD AND COGNITION

Has your memory been getting worse lately? Yes No

Have you had difficulty concentrating lately? Yes No

Have you been feeling more irritable lately? Yes No

Have you ever been treated for anxiety, depression or severe stress? Yes No

Please explain: _____

Have you been feeling more depressed lately? Yes No

How much stress would you say you are under right now? More than usual Less than usual The same

Is your stress related to: (Please check all that apply) Work Personal Other

Have you felt: Hopeless Helpless Worthless Useless

How is your appetite?: Worse than usual Better than usual The same

Have you had any suicidal thoughts lately? Yes No

In response to intense emotion (laughter, anger, surprise) have you felt sudden muscle weakness in your legs, neck or other extremities? Yes No

Please explain: _____

Before you are fully asleep, do you have vivid, sometimes frightening dream like hallucinations? Yes No

Please explain: _____

Have you ever wakened from sleep and felt like your body was "paralyzed" and you could not move even though you could see and breathe? Yes No

Do you ever have difficulty falling asleep do to pain, cramping, twitching or a crawling sensation in your legs? Yes No