MEDICAL PROLEMS: *PLEASE CIRCLE*

High Blood Pressure High Cholesterol
Diabetes Atrial Fibrillation Stroke
Anemia Arthritis Nasal Allergies
Asthma Hypothyroidism Seizures
Heart Murmur Chronic Lung Disease
Depression/Anxiety Bipolar Depression
Gastric Reflux Peripheral Neuropathy
Heart Attack Fibromyalgia Back Pain
Skin Cancer Compulsive Disorders

Other:______________________________

PAST SURGERIES: *PLEASE CIRCLE*

Tonsillectomy/Adenoidectomy Uvuloplasty
Sinus Surgery Deviated Septum Repair
Arthroscopy Back Surgery Gall Bladder
Thyroidectomy Appendectomy Pacemaker
Coronary Artery Bypass Heart Stent
Hernia Repair Carpal Tunnel Hysterectomy
Joint Replacement which joint?_______________

Other:______________________________

PLEASE LIST (*OR ATTACH*)
YOUR MEDICATIONS *Doses/Times*

(include over the counter and herbal meds)

____
____
____
____
____
____
____
____

Do you have *Medication* allergies? ***NO***

YES: ______________________________

____

Do you smoke: ***YES*** ***NO***

_____ *packs/day* *How long*_____ *years*

List the beverages that you drink:
Amount / Time of day

Regular coffee or tea ____________________

Caffeinated Soft drinks ____________________

Alcohol *(beer/wine/cocktails)* ________________

What is your weight now ________

wt 5 yrs ago ________ ***wt 10 yrs ago*** ________

Do sleep problems run in your family:

☐ Sleep Apnea ☐ Insomnia ☐ Narcolepsy

☐ Restless leg syndrome ☐ Other_______________

Who?_____________________________________

List the name of the Health Care Provider that you would like to receive information:

Name:______________________________

Take the following sleep quiz to see if you are sleepy.

The Epworth Sleepiness Scale

Score 0 - No chance, 1 = slight chance of dosing
2 = moderate chance of dozing 3 = high chance of dozing

Situation	Chance of Dozing
Sitting and Reading	_______
Watching TV	_______
Sitting inactive in a public place (church)	_______
As a passenger in a car for 1 hour without a break	_______
Lying down to rest in the afternoon	_______
Sitting and talking with someone	_______
Sitting quietly after lunch without alcohol	_______
Driving a car, stopped for a few minutes in traffic	_______
Total	_______

If you score 10 or greater you are sleepy

Please fill out and
bring with you
to your consultation

Sleep Questionnaire

SLEEP DIAGNOSTICS OF NORTHERN MICHIGAN

Your Sleep Is Our Concern

David A. Walker, D.O., D.ABSM

550 Munson Avenue Ste. 202
Traverse City, MI 49686
231.935.9275

Please complete this questionnaire and bring with you

NAME________________________________

Describe your sleep concern(s):

____

____

How long have you had sleep problems?

____

Have you had a previous sleep study?______

If so, when ________ where_______________

What were the results?___________________

Do you have trouble falling asleep? YES NO
Do you have trouble staying asleep? YES NO
What wakes you up?

Snoring *Unsure* *Need to urinate*

Gasping or Choking *Short of breath*

How many times do you wake up__________

How long are you then awake_____________

How many hours do you sleep____________

Are you told that you snore? YES NO

Are you told that you stop breathing during your sleep? YES NO

Where do you normally sleep?

Bed Recliner Adjustable bed other:_____

What time do you:

go to bed_________ fall asleep____________
get up_________ on your days off_________

What is your occupation_________________

What hours do you work_________________

Do you feel refreshed when you wake up?

YES NO

Do you wake up with headaches?

NO 1-2x/week 3-5x/week Daily

During sleep do you experience:

Heart Palpitations	YES	NO
Indigestion or Reflux	YES	NO
Nasal congestion	YES	NO
Teeth grinding or clenching	YES	NO
Do you wear a bite splint?	YES	NO

Do you experience chronic pain? If so, how do you grade your pain on the following scale?

No pain *1 2 3 4 5 6 7 8 9 10* severe pain

Where is your pain?_____________________

Does it wake you up at night?____________

Do you Have Restless Leg Syndrome?

This is described as an unpleasant sensation in your legs with an ***urge*** to move or stretch your legs to make them feel better. ***These symptoms often begin in the evening or at bedtime.***

NO 1-2x/ Month 1-2x/week Daily

Does your mind race making it difficult to fall or stay asleep: *YES NO*

Do you experience Depression or Anxiety: *YES NO*

Have you become increasingly irritable or short tempered: *YES NO*

Do you feel tired or sleepy during the day:

NO YES: time of day: ________

Do you take NAPS during the day:

NO YES: Daily 1-2x/week 3-5x/week

How long are your naps ____________

Are they refreshing YES NO

Do you fall asleep at work or at meetings:

Never Rarely 3-5x/week Daily

Do you sleep walk, sleep eat or sleep talk, or have nightmares?______________________

____

Have you acted out a dream or fallen out of bed or injured a bed partner?

NO *YES (describe)*

____

____

When falling asleep or wakening up, have you ever felt as if you were awake but paralyzed for a short while:
(Not numbness or tingling of arms or legs)

Never Rarely 3-5x/week Daily

Do you ever feel as though you are imagining (seeing or hearing things) as you fall asleep or when you are waking up:

Never Rarely 3-5x/week Daily

Do you experience muscle weakness with laughter, surprise or anger? *YES NO*

While DRIVING: do you get sleepy, drowsy, tired, or fatigued:

Never Rarely 3-5x/week Daily

Do you pull off the road to nap or rest:

YES NO

Do you cross the center line or run off to the side of the road while driving drowsy:

NO YES: ___X's/year ___X's/month Daily

Do you have a commercial drivers license or are you applying? *YES NO*