Henry Ford Sleep Disorders Center
New Patient Questionnaire

Name: _____

What is the reason for your referral to the Sleep Center?

_____

Who referred you to the Sleep Center? _____

Please mark any of the following symptoms that you have experienced recently:

Night time symptoms:
___ Snoring
___ I have been told I stop breathing during sleep
___ Waking up with choking or gasping sensation
___ Dry mouth upon awakening
___ Headaches in the morning
___ Waking up feeling tired and not refreshed
___ Using the bathroom more than 2 times a night

___ Kicking your legs during sleep
___ Sleepwalking
___ Talking in your sleep
___ Acting out your dreams or punching/kicking
___ Nightmares
___ Heartburn (reflux) at night
___ Grinding teeth at night

Have you had your tonsils removed? ____
Have you ever had a sleep study or been diagnosed with sleep apnea? ____
Have you ever had surgery for sleep apnea?___

Sleep and work schedule:
Do you work shifts? ___
Do you travel for work? ___
What are your work hours: _____
Do you have difficulty falling or staying asleep? __
Do you take a sleeping medication? _____

Daytime Symptoms:
___ Excessive daytime sleepiness
___ Problems staying awake when driving
___ Forgetfulness or decreased concentration
___ Making errors at school or work
___ Irritability

___ Being unable to move when you wake up
___ Sudden body weakness or buckling brought by emotion
___ Seeing or hearing things when falling asleep or waking up

___ Uncomfortable restlessness in the legs as you are trying to fall asleep
Does this improve briefly with moving the legs? __
What time of day is this most bothersome? ___

Family history:
Has anybody in your family suffered from:
___ Sleep apnea or snoring
___ Insomnia
___ Restless leg syndrome
___ Significant excessive sleepiness

	Work/school days	Days off
What time do you go to bed		
What time do you try to fall asleep		
How long does it take you to fall asleep		
How many times do you wake up at night		
How long are you awake at night		
What time do you wake up for the day		
What time do you get out of bed		
Do you take naps		
How much sleep do you think you get		

OVER

TAKING EVERYTHING IN YOUR LIFE INTO ACCOUNT, PLEASE RATE YOUR OVERALL QUALITY OF LIFE ON THE FOLLOWING 7 POINT SCALE.

One (1) means life is very distressing, it's hard to imagine how it could get much worse.
Seven (7) means life is great; it's hard to imagine it could get better.
Four (4) means life is so-so; neither good nor bad.

1	2	3	4	5	6	7
Life is very distressing			Life is so-so			Life is great

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS, IN CONTRAST TO FEELING JUST TIRED? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze 2 = moderate chance of dozing
1 = slight chance of dozing 3 = high chance of dozing

Situation	Chance of Dozing (0-3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
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 a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	

PLEASE CIRCLE THESE ADDITIONAL SYMPTOMS THAT YOU MAY HAVE EXPERIENCED RECENTLY:

Constitutional: Fever Weight gain Weight loss
Ears, Nose, Throat: Trouble hearing Sinus problem Trouble speaking Trouble swallowing Nose bleeds Nasal congestion Deviated septum
Eyes: Change in vision Dryness
Neurologic: Headaches Seizures Memory loss Stroke Balance problems Weakness Clumsiness Tremor/shakiness
Cardiovascular: Chest pain Irregular heart beat Heart attack High blood pressure
Respiratory: Shortness of breath Wheezing Cough COPD Asthma
Gastrointestinal: Abdominal pain Diarrhea Constipation Ulcers Bleeding
Genitourinary: Difficulty urinating Urgency to urinate Frequent urination Sexual problems
Endocrine: Heat intolerance Cold intolerance Excessive thirst Thyroid problem
Allergic/Immunologic: Allergies to food Allergies to pets or mold
Hematologic/lymphatic: Easy bruising Bleeding Swollen glands
Musculoskeletal: Muscle aches Joint aches Backache Swelling in legs Frequent falls
Psychiatric: Change in mood Depression Anxiety Thoughts to hurt yourself
Skin: Rashes Itching