WMED HEALTH
THE CLINICAL PRACTICE OF WESTERN MICHIGAN UNIVERSITY HOMER STRYKER M.D. SCHOOL OF MEDICINE

Sleep Health
Adult Health Assessment

Date:	Date of Birth:	
Last Name:	First Name:	Middle Initial:
Preferred Pharmacy/Location:		

Do you have an advance directive? ☐ Yes ☐ No

Do you currently use or have a preferred durable medical supply company? ☐ Yes ☐ No If yes, who: ______________________

Providers caring for you (family doctor, specialist, psychologist, dentists, etc.)

____

____

Main Complaint

What is your main sleep or alertness complaint? How long has it occurred? Or why are you having this test?

____

If you have ever had a sleep study, please indicate when and where.

____

If you are excessively sleepy or fatigued, how long has this been going on? Do you have any ideas as to why this is happening?

____

____

What is the sleepiest time of day? ____

Have you ever been in any motor vehicle crashes or near misses associated with drowsiness /excessive sleepiness? ☐ Yes ☐ No

Sleep Routine

When do you go to bed on weekdays? ______________________ Weekends? ______________________

What time do you get up on weekdays? ______________________ Weekends? ______________________

How long does it take to fall asleep?______________________ Do you have trouble falling asleep?______________________

How often do you awaken at night? ______________________ What causes it? ______________________

How long does it take to fall back to sleep?______________________ How often do you urinate at night? ______________________

How many hours of sleep do you get in a typical night? ______________________

Do you sleep alone? ☐ Yes ☐ No

How do you feel when you wake up? ______________________

Do you have anemia or "iron poor blood"? ☐ Yes ☐ No

Have you ever been told you have restless leg syndrome (RLS)? ☐ Yes ☐ No

Do you have an urge to move your legs accompanied by an uncomfortable sensation in your legs? ☐ Yes ☐ No (If No please skip the indented questions)

Is the urge to move your legs worse during periods of inactivity? ☐ Yes ☐ No

Are your symptoms relieved by movement? ☐ Yes ☐ No

Are your symptoms worse in the evening or night time? ☐ Yes ☐ No

Are your symptoms worse when you are in confined spaces (such as a meeting, theater, car, etc.)? ☐ Yes ☐ No

Sleep Events

While asleep do you:	Never	Occasionally	Often	Always
Have heartburn or chest pain?	1	2	3	4
Grind teeth?	1	2	3	4
Drooling?	1	2	3	4
Have jerks or twitches?	1	2	3	4
Have nightmares?	1	2	3	4
Sleep in an unusual position?	1	2	3	4
Cough?	1	2	3	4
Wake up with headaches?	1	2	3	4
Wake up with a sore throat?	1	2	3	4
Wake up with a dry mouth?	1	2	3	4
Toss and turn restlessly?	1	2	3	4
Gasp or choke?	1	2	3	4
Stop breathing?	1	2	3	4

Snoring Scale (circle one)

5 – Snoring is continuous and so loud, it can be heard despite being in a different room and using earplugs: "heroic snoring"

4 – Snoring is continuous and so loud, I must go to another room or use earplugs in order to sleep: "persistent terrible snoring"

3 – Snoring is frequently loud enough so that I awaken and nudge him/her so he/she will turn over and stop snoring "persistent loud snoring"

2 - Snoring occurs daily, but is a soft snore

1 - Snoring is present, but does not disturb me or bother my sleep: "occasional soft snore"

0 – No snoring

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Parasomnias

Do you sometimes awaken with the feeling you are completely paralyzed? ☐ Yes ☐ No

Do you ever hallucinate sights or sounds while falling asleep as if your dreams are beginning before you are fully asleep?

☐ Yes ☐ No ______________________________

Do you sleep walk, talk or moan? ☐ Yes ☐ No ______________________________

Do you perform unusual behaviors during sleep? ☐ Yes ☐ No ______________________________

Do you have brief attacks of muscle weakness? ☐ Yes ☐ No ______________________________

Sleep Hygiene

Do you drink beverages with caffeine (coffee, tea, cola, Mountain Dew, etc.) or take caffeine pills? ☐ Yes ☐ No

If so, how much, what time of day? ______________________________

How much chocolate do you eat or drink on an average day? ______________________________

Do you exercise routinely? ☐ Yes ☐ No If so, what time of day? ______________________________

Do you do anything stressful or anxiety provoking before going to bed? ☐ Yes ☐ No If so, please describe: ______________________________

____

Is there anything in your bedroom that could be disturbing your sleep? ☐ Yes ☐ No (room temperature, noise, pets, etc.) ______

____

Do you nap more than once a week? ☐ Yes ☐ No If so, please describe: ______________________________

____

Social History

Do you smoke or otherwise use tobacco? ☐ Yes ☐ No If so, how much a day? ______________________________

Recreational drug use / substance abuse: ______________________________

How much alcohol do you drink per week? ______________________________

Occupation ______________________________ Shift ______________

Who lives at home? ______________________________

Marital status ______________________________

Number of children ______________________________

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PAST MEDICAL HISTORY – INFORMATION ABOUT **YOU**		
☐ Asthma	☐ Heart Failure	☐ Pulmonary Hypertension
☐ Cerebrovascular Disease (Stroke)	☐ High Cholesterol	☐ Seizure Disorder
☐ Chronic Pain	☐ Hypertension (High Blood Pressure)	☐ Sleep Apnea
☐ COPD/Emphysema	☐ Menopause	☐ Thyroid Disease
☐ Coronary Heart Disease	☐ Mental Disorder ____________________	☐ Other: ___________________________
☐ Diabetes	☐ Peripheral Vascular Disease (PVD)	☐ Other: ___________________________
PAST SURGICAL HISTORY – INFORMATION ABOUT YOU		
☐ Back Surgery	☐ Prostate Surgery	☐ Total Knee Replacement
☐ Carotid Endartectomy	☐ Rotator Cuff Repair	☐ Vasectomy
☐ Eye Surgery	☐ Shoulder Surgery	☐ Other: ___________________________
☐ Heart Surgery	☐ Sleep Apnea Surgery	☐ Other: ___________________________
☐ Hernia repair	☐ T&A (Tonsils & Adenoids)	☐ Other: ___________________________
☐ Hysterectomy	☐ Tubal Ligation	☐ Other: ___________________________
☐ Knee Surgery	☐ Total Hip Replacement	☐ Other: ___________________________
FAMILY HISTORY- Please list which blood relatives		
☐ Idiopathic Hypersomnia	☐ Narcolepsy	☐ Sleep Apnea
☐ Insomnia	☐ Restless Leg Syndrome	☐ Snoring

REVIEW OF SYSTEMS					
Constitution			**Cardiovascular**		
Fatigue	Y	N	Chest pain	Y	N
HENT (eyes, ears, nose, throat)			Leg swelling	Y	N
Congestion	Y	N	Palpitations	Y	N
Eye redness	Y	N	**Neurological**		
Nose bleeds	Y	N	Headaches	Y	N
Sore throat	Y	N	**Allergy/Immunology**		
Respiratory (breathing)			Environmental allergies	Y	N
Apnea	Y	N	**Psychiatric**		
Cough	Y	N	Decreased concentration	Y	N
Shortness of breath	Y	N	Difficulty concentrating	Y	N
GI			Irritability	Y	N
Abdominal distention	Y	N	Mood swings	Y	N
Abdominal pain	Y	N	Sleep disturbance	Y	N
Heart burn / reflux	Y	N	**Endocrine**		
Skin			Cold intolerance	Y	N
Rash	Y	N	Heat intolerance	Y	N

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Additional Information

Do you now or have you ever used any medications to help you sleep? If so, what? When? ______________________________

Is there anything else that you feel may be important for the physician to know about your sleep and alertness problems or your health? ☐ Yes ☐ No

____

____

____

Bed Partner / Sleep Observer Questionnaire

Observer's Relationship to the Patient ______________________________

How often have you observed this person's sleep?		Never	Once or Twice	Often	Every Night
The patient snores when sleeping on/in:	The back only	Sides too	All positions	Doesn't snore	I don't know
The patient's snoring is:	Soft	Medium	Loud	Variably present	Always present
The patient has trouble breathing normally during sleep when:		Sleeping on back	Sleeping on sides	All positions	Never has trouble
The patient's snoring and/or breathing pattern can disrupt my sleep.				Yes	No
The patient may snort, gasp, cough, or choke during sleep.				Yes	No
The patient seems to have pauses in breathing or to stop breathing during sleep.				Yes	No
The patient often is excessively sleepy during the day.				Yes	No
The patient often has trouble staying awake while driving.				Yes	No
The patient is often difficult to awaken in the morning.				Yes	No
The patient awakens with pain.				Yes	No
The patient often has difficulty with their memory and concentration.				Yes	No
The patient often complains of a headache upon waking from sleep.				Yes	No
The patient has an irregular sleeping / wake schedule.				Yes	No
The patient's frequent arm, leg or body movements bother my sleep.				Yes	No
The patient frequently exhibits unusual, abnormal behavior during sleep.				Yes	No
The patient frequently has no energy for activities with family and friends.				Yes	No
The patient frequently has trouble getting to sleep and/or falling asleep.				Yes	No
The patient grinds teeth during sleep.				Yes	No
The patient becomes very rigid during sleep.				Yes	No
Additional information:					