

BRONSON Sleep Health Specialists/Sleep Lab – 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.

Daytime Sleepiness

How would you rate your usual daily sleepiness?	Chance of dozing			
	Never	Occasionally	Often	Always
Situation:				
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g theatre, meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

What is the sleepest time of day? _____

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

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?

Sleep Routine

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

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

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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? _____

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

Do you have anemia or "iron poor blood"? 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

<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Pulmonary Hypertension
<input type="checkbox"/> Cerebrovascular Disease (Stroke)	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Hypertension (High Blood Pressure)	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> Menopause	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Coronary Heart Disease	<input type="checkbox"/> Mental Disorder _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Peripheral Vascular Disease (PVD)	<input type="checkbox"/> Other: _____

PAST SURGICAL HISTORY – INFORMATION ABOUT YOU

<input type="checkbox"/> Back Surgery	<input type="checkbox"/> Prostate Surgery	<input type="checkbox"/> Total Knee Replacement
<input type="checkbox"/> Carotid Endarterectomy	<input type="checkbox"/> Rotator Cuff Repair	<input type="checkbox"/> Vasectomy
<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Shoulder Surgery	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Sleep Apnea Surgery	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hernia repair	<input type="checkbox"/> T&A (Tonsils & Adenoids)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Knee Surgery	<input type="checkbox"/> Total Hip Replacement	<input type="checkbox"/> Other: _____

FAMILY HISTORY

<input type="checkbox"/> Idiopathic Hypersomnia	<input type="checkbox"/> Narcolepsy	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Restless Leg Syndrome	<input type="checkbox"/> 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

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

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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 ridged during sleep.				Yes	No
Additional information:					