

DEARBORN SLEEP LAB - PATIENT QUESTIONNAIRE

Division of Millennium Medical Group South, P.C.

Date:		Patient Name:	
Patient Birthdate:		Gender:	
Height:	Weight:	Neck Size:	
Name of Family Doctor: _____			
Doctor's Address: _____			
Doctor's Phone: _____			
Present living situation: <input type="checkbox"/> Living with family <input type="checkbox"/> Living with other relatives <input type="checkbox"/> Living with friends <input type="checkbox"/> In a nursing home <input type="checkbox"/> Alone			
What is/was your main line (area) of work?			
If you are not presently working, check one of the following: <input type="checkbox"/> Retired <input type="checkbox"/> Laid off <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Disability <input type="checkbox"/> Recently fired <input type="checkbox"/> Other			
If on Worker's Compensation or disability, please explain:			
If working, what are your usual working hours?			
Begin at	AM / PM	End at	AM / PM
Does your job have rotating shifts or night work?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you drive a car?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is driving any type of vehicle a part of your job description?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please describe:			
Do you feel drowsy while driving?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, is this with:		<input type="checkbox"/> Short distance	<input type="checkbox"/> Long distance
How long can you drive before you are bothered by sleepiness?			
Have you ever been in a car accident due to falling asleep at the wheel?			
<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Have you had a "near miss" auto accident due to sleepiness?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Do you now experience, or have you ever experienced in the past, any health problems associated with the areas listed below? Please include any surgeries you have had.</i>			
Type of Problem	Yes	No	If Yes, Please Explain
Mental Health			
Head/Nervous System			
Eyes/Ears/Nose/Throat			
Heart/Circulation			
Breathing/Lungs			
Stomach/Digestive			
Urine/Kidneys			
Bones/Joints/Arms/Legs			
Diabetes/Glands			
Sexual Problems			
Other			

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Do you snore every night?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been told you snore in certain positions? <i>Check all that apply</i>			
<input type="checkbox"/> On your back	<input type="checkbox"/> Side	<input type="checkbox"/> Stomach	<input type="checkbox"/> Sitting
Do you awaken snoring or gasping?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been told that you stop breathing during sleep?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you take naps during the day?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
How many naps per day (average)?		_____	
How long do you nap (in hours and/or minutes)?		_____	
Do you wake up from the naps refreshed?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have difficulty breathing through your nose?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, check which applies:		<input type="checkbox"/> Daytime	<input type="checkbox"/> At night
		<input type="checkbox"/> Both	
Have you ever been told that you have large tonsils, a deviated septum, or allergies?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, explain:			
Have you ever experienced weakness or paralysis when:			
<input type="checkbox"/> Going to sleep	<input type="checkbox"/> Waking up		
Have you ever had funny sensations in your legs before or after sleep?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If yes, which apply?			
<input type="checkbox"/> Aching	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Creeping and crawling	<input type="checkbox"/> Twitching
Has anyone ever told you that your arms or legs jerk or twitch while you sleep?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Have you ever suddenly fallen or experienced sudden body weakness in your legs or jaw while still being aware of your surroundings?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes was this ever brought on by any of the following?			
<input type="checkbox"/> Laughter	<input type="checkbox"/> Fright	<input type="checkbox"/> Strong Emotion	
Use the following scale to describe your chance of falling asleep:			
0 = Would never doze or sleep	1 = Slight chance of dozing or sleeping		
2 = Moderate chance of dozing or	3 = High chance of dozing or sleeping		
Situation		Chance of Dozing	
Sitting and reading			
Watching TV			
Sitting inactive in a public place (i.e. theater 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 traffic			
Total			
Score:	0-10	Normal Range	10-12
			Borderline
			12-24
			Abnormal