THE SLEEP DISORDERS CLINIC

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PATIENT QUESTIONNAIRE

Date: _____/_____/_____

Name: _____ Date of Birth _____

Address: _____Gender: _____

Phone number: _____Cell phone/ alt phone: _____

Health card number: _____Version Code_____ Email address: _____

Height: _____ Weight:_____

□ Yes □ No Is your weight stable? If no: gain / loss How much: _____

□ Yes □ No Have you ever had a sleep study? If yes, when: _____
Where? _____

□ Yes □ No Have you ever had a CPAP study? If yes, when: _____
Where? _____

□ Yes □ No Are you on CPAP? Pressure_____ □ Yes □ No Are you on BIPAP? _____/_____

□ Yes □ No Are you able to care for yourself in the sleep lab? If no please tell us why_____
□ Yes □ No Do you have trouble getting in and out of bed? If yes please tell us why_____
□ Yes □ No Do you use a walker, wheel chair or other mobility aid? Please explain _____
□ Yes □ No Do you have any trouble understanding, speaking or writing English? If yes please explain _____
□ Yes □ No Is there anything else we should know to plan for your overnight study?_____
□ Yes □ No Do you have any open wounds or a history of hospital acquired infections? _____
□ Yes □ No Do you need to be accompanied to your overnight sleep study? If yes_____
□ Yes □ No Are you tired during the day?
□ Yes □ No Do you experience tiredness while driving?
□ Yes □ No Have you ever fallen asleep while driving?
□ Yes □ No Have you ever had an accident due to tiredness or falling asleep while driving?
If yes, please provide details:

MEDICATIONS: Please list the medications that you are taking and dosage if you know it.

1._____ **6.** _____
2._____ **7.**_____
3. _____ **8.** _____
4. _____ **9.** _____
5. _____ **10.** _____

Do you take any medications to help you sleep, including over the counter preparations? □ Yes □ No -
_____

Do you have any medication allergies? □ Yes □ No _____

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 have not 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**

CHANCE OF DOZING / SLEEPING **(please circle most appropriate number)**	**SITUATION**
0 1 2 3	Sitting and reading
0 1 2 3	Watching T.V.
0 1 2 3	Sitting, inactive in a public place (theatre or 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

TOTAL: _____/24 (Add each number up and give a total out of 24)

Social History:

Who do you live with? _____

Marital Status: _____Occupation: _____

□ Yes □ No Do you drink tea/ coffee/ cola with caffeine?

If yes, how many per day? _____(total #).

□ Yes □ No Do you drink alcohol? □ Yes □ No Do you drink every day?

If yes, how many drinks per day?_____ (total #) If no: How many drinks per week? _____(total #)

□ Yes □ No Do you smoke? _____# per day? □ Yes □ No Have you quit?

When did you quit? _____Total years of smoking: _____

□ Yes □ No Do you get regular exercise? _____

Sleep History:

What time do you normally turn your lights out to go to sleep?

What time do you normally wake up?

How long does it normally take you to get to sleep?

□ Less than 5 minutes □ 5 – 30 minutes □ 30 – 60 minutes □ Longer than 1 hour

How many times do you wake up to use the washroom?

Besides to use the washroom, how many times do you wake up in the night?

In the past week, how many hours did you sleep, per night, on average?

□ Yes □ No Do you routinely sleep with children or pets in your bed?

□ Yes □ No Do you routinely sleep with the TV on, or is there other noise that disturbs your sleep? If yes, explain:

□ Yes □ No Do you work shifts or irregular hours? Explain:

□ Yes □ No Do you snore? How loudly do you snore (please circle)?

From soft 1 2 3 4 5 6 7 8 9 10 to loud

□ Yes □ No Has anyone thought you stopped breathing in the night?

□ Yes □ No Do you choke at night?

□ Yes □ No Do you gasp for air at night?

□ Yes □ No Does your bed partner poke you to stop snoring? N/A

□ Yes □ No Does your bed partner poke you if you stop breathing? N/A

□ Yes □ No Have you gained weight? If yes, how much and over how long?

□ Yes □ No Are you a restless sleeper?

□ Yes □ No Do you suffer from nightmares on a regular basis?

□ Yes □ No Do you hit out or move when you are dreaming?

□ Yes □ No When you get up in the morning do you feel refreshed?

□ Yes □ No Do you ever feel confused when you awaken from sleep?

□ Yes □ No Do you ever sleep walk?

□ Yes □ No Do you ever sleep talk?

□ Yes □ No Have you ever had seizures or been diagnosed with epilepsy? If yes please explain.

□ Yes □ No Do you ever feel weak when you hear or tell a joke?

□ Yes □ No Do you have hot flashes or sweats at night?

□ Yes □ No For women only: Are you menopausal? □ No □ Yes Post- menopausal?

□ Yes □ No Do you ever wet the bed?

□ Yes □ No Do your legs twitch or jerk at night during your sleep?

□ Yes □ No Do your legs feel restless whenever you sit down or lie down causing you to get up and walk around?

□ Yes □ No Do you grind your teeth? □ Yes □ No Do you wear a mouth guard at night?

□ Yes □ No Are you tired during the day?

□ Yes □ No Do you take naps during the day? If yes, are they refreshing?

□ Yes □ No Do you find that your mind is not working as quickly or that you are more forgetful?

□ Yes □ No Have other people told you that you are more short tempered or irritable recently?

□ Yes □ No Have you had trouble having sex recently? N/A

□ Yes □ No Does your partner sleep in another room? If yes, why? N/A

Medical History:

□ Yes □ No Do you have high blood pressure? If yes, is it hard to control with medication?

□ Yes □ No Do you have heart disease? If yes, do you have difficulty controlling the symptoms with medication?

□ Yes □ No Do you have aches and pains in your joints? If yes, cause?

Do you wake up with □ Sore throat □ Dry mouth □ Nasal Congestion?

□ Yes □ No Do you have trouble breathing through your nose?

□ Yes □ No Has your nose ever been broken? □ No □ Yes Do you have a deviated septum?

□ Yes □ No Have your tonsils been removed? If yes, at what age?

□ Yes □ No Have your adenoids been removed? If yes, at what age?

□ Yes □ No Have you had surgery to remove the uvula?

□ Yes □ No Have you had any other throat or nose surgery? If yes, explain:

Do you have any of the following? (Check all that apply)

☐ Asthma ☐ Depression ☐ Diabetes

☐ Gastroesophageal Reflux Disease (GERD) ☐ Chronic Obstructive Pulmonary Disease

☐ Yes ☐ No Do you have a small chin and receding jaw?

☐ Yes ☐ No (Men only) Is your collar size 17" (42 cm) or larger?

☐ Yes ☐ No Do you have any family members or relatives that have sleep apnea?

PARENTS

Mother

Is your mother alive? ☐ Yes ☐ No
If yes, how old? _____
If no, how old was she at the time of death? _____

What did she die of? _____
Did your mother have any illnesses of note?
(Heart disease, diabetes)

_____
_____

_____

Father

Is your father alive? ☐ Yes ☐ No
If yes, how old?_____
If no, how old was he at the time of death?_____

What did he die of?_____
Did your father have any illnesses of note?
(Heart disease, diabetes)

_____
_____

_____

Have any family members been diagnosed with a sleep problem or other significant health problems? Please explain;

_____
_____
_____

HOSPITAL ADMISSIONS:
Please list all times that you have been in hospital, starting with the most recent.

Year	**Reason for Admission**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PHYSICIANS
Please list the names of ALL physicians who are currently taking care of your health needs.

Name	**Specialty**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ILLNESSES OF NOTE

Please list any illness of note and years if applicable.

Illness	**Date Diagnosed**	**Ongoing?**
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

Why do think your doctor has sent you to the Sleep Disorders Clinic?

_____
_____
_____

Thank you for taking the time to fill in this questionnaire. **Please bring it with you to your sleep study.**

All patients' information is kept strictly confidential except where required to be divulged by law.