West Ottawa Sleep Centre

Sleep Diagnostic Lab

Intake Questionnaire – Sleep Habits and Disorders

Name _____ todays date_____

Date of Birth Year_____ Month _____ Day_____

Height _____ Weight_____ Gender _____ Age _____

Your Occupation_____

TECH USE ONLY
HEIGHT ____ft____inches
WEIGHT_____ lbs
NECK SIZE _____ inches
BMI

Please describe your main concerns or problems with your sleep:

Your usual sleep habits:

Bedtime_____ Time to fall asleep_____ Wake up time ____ Total hours _____

On average, how many times a night do you wake up? _____

Do you work evenings, nights, or a rotating schedule? If so please describe

Do you have any of the following problems? (please circle YES or NO)

Snoring and Sleep apnea

1) Do you snore? YES NO

2) Do you wake with trouble breathing do to choking or feeling short of breath YES NO

3) Did anybody tell you that you stop breathing during sleep? YES NO

4) Are you excessively sleepy during the day? YES NO

5) Must you take a nap most days of the week? YES NO

6) Did you fall asleep while at work in the past 12 months? YES NO

7) Did you fall asleep while driving a car in the past 12 months? YES NO

8) Is your nose normally congested or blocked? YES NO

9) Have your tonsils been removed? YES NO

10) Have you ever had surgery for snoring? YES NO

11) Have you ever had a stroke? YES NO

12) Have you ever had a heart attack? YES NO

13) Do you have angina (heart pains)? YES NO

14) Do you have COPD, emphysema or asthma? YES NO

15) Do you have leg discomfort or restlessness while trying to fall asleep? YES NO

If YES, does moving your legs around help reduce the discomfort?

If YES, how may nights a week does it occur? ____ nights per week.

If YES, does it interfere with your ability to fall asleep?

16) Do your legs twitch or jump at night? YES NO

If YES, how many nights a week does it occur? ___ nights per week.

If YES, do the movements awaken you from sleep? _____

17) Has a doctor told you that you have anemia (low blood)? YES NO

18) Has a doctor told you that you have a vitamin or mineral

deficiency? (e.g. vitamin B12, folate, iron) YES NO

19) Has a doctor told you that you have a kidney disease? YES NO

20) Do you have persistent numbness or discomfort in your toes during the day? YES NO

21) Do you take anti-depressants? YES NO

22) Do you have diabetes? YES NO

23) Do you have trouble falling asleep? YES NO

24) Do you have trouble staying asleep? YES NO

25) Does pain disturb your sleep? YES NO

26) Is your bedroom noisy or uncomfortable to sleep in? YES NO

27) Do you suffer from depression? YES NO

28) Do your muscles become unusually weak, or do you lose your

Strength when you are very emotional (e.g. laughing, angry, excited)? YES NO

29) Do you feel totally paralyzed on awakening form sleep, or on falling asleep? YES NO

30) Do you see or hear things that aren't really there as you fall asleep? YES NO

32) Do you wake up with a sore jaw in the morning? YES NO

33) Do you grind your teeth at night? YES NO

If YES do you wear an oral appliance? YES NO

34) Do you behave in unusual ways during sleep? YES NO

(circle all that apply: talk, yell, scream, walk, hit, punch, shake, twitch, bed wet, jump)

If YES, please describe

Please list all illnesses or heath problems that you currently have:

Please list all the treatments and medications that you currently take

(include oxygen, inhalers, over the counter medications,_____

_____

_____

_____

_____

Are you currently on CPAP, What pressure _____H20**):**

_____

How many caffeinated beverages do you drink each day, on average

(coffee, tea, cola)_____

What time of the day/evening do you have your last caffeinated beverage?_____

How many alcohol-containing beverages do you drink each day on average?_____

How many alcohol-containing beverages did you drink this evening? _____

How many cigarettes do you smoke each day, on average? _____

What time of the day/evening did you have your last cigarette? _____

Have you ever had a sleep study before? When _____ Where _____

There is one final page…..

WOSC Patient Emergency Information

Patient's Name:_____

Person to notify in the event of an emergency:_____

Relationship: spouse_____ parent_____ Friend _____

Your email address _____

Their phone number today: _____Other phone numbers for that person:_____

Parts of this sleep study maybe video recorded.

I, _____ acknowledge and give my consent to record parts of this sleep study as deemed necessary by the night technologist.

The Epworth Sleepiness Scale

How likely are you to doze off 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 affect you.

Using the following scale to choose the **most appropriate number** for each situation.

would **never** doze **0**

slight chance of dozing **1**

moderate chance of dozing **2**

high chance of dozing **3**

Situation	Chance of Dozing
Sitting and reading	0 1 2 3
Watching T.V.	0 1 2 3
Sitting, inactive in a public place (theater 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, stopped for a few minutes in traffic	0 1 2 3

Total _____/24