Sleep Disorder Centre
Patient Sleep History

In order that we may process your referral on a timely basis, please ensure that you have completely filled out the following information. Failure to complete each section may result in a delay in providing your appointment.

All data is confidential and no patient identifiers are used.
***Do you consent to this clinical information and/or your sleep study data being used for research purposes? □ Yes □ No**

Today's Date: _____

First Name: _____ **Last Name:** _____

Date of Birth: ____ _____ _____
dd mm yyyy

HEALTH CARD:

Manitoba Health Number (MHSC) (6 digit): __ __ __ __ __ __

Personal Health Identification Number (PHIN) (9 digit): __ __ __ __ __ __ __ __ __

	Yes	No	Number	
Canadian Military	□	□	_____	
Out of Province	□	□	_____	
Aboriginal Treaty	□	□	_____	Do you live on a Reserve? □ **Yes** □ **No**

PATIENT CONTACT INFORMATION:

Mailing Address/Postal Code: _____

Home: _____ **Cell:** _____ **Work:** _____ **Message:** _____

EMERGENCY CONTACT INFORMATION:

Name: _____ **Relationship:** _____ **Phone Number:** _____

REFERRING PHYSICIAN: Name: _____ **Address:** _____

FAMILY PHYSICIAN: Name: _____ **Address:** _____

Weight: _____ **Height:** _____

What are your major concern(s) regarding your sleep? (check all that apply)**:**

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Non-refreshing, broken sleep
- ☐ Feeling sleepy during the day
- ☐ Feeling very tired during the day
- ☐ Difficulties breathing in my sleep
- ☐ Snoring and/or stopping breathing bothers my partner
- ☐ Urge to move my legs at night
- ☐ Strange behavior in my sleep (excess movement, sleep walking, etc.)
- ☐ Pain disrupts my sleep
- ☐ Other: _____

Highest Education Level: ☐ High School ☐ Post-Secondary

Type of Occupation: (check any that apply)

- ☐ Drivers who admit they have fallen asleep driving, within the last 2 years
- ☐ Work with Machinery, Hazardous Occupation
- ☐ Commercial Driver
- ☐ Railway Engineer
- ☐ Pilot
- ☐ Air Traffic Controller, Airplane Mechanic
- ☐ Ship Captain
- ☐ Health Care Occupation
- ☐ Child Care Occupation

Evening/Night Shift(s)? ☐ Yes ☐ No

Do you operate heavy/dangerous equipment/transport vehicles (tractor, bus, ambulance)? ☐ Yes ☐ No

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Please answer the following questions as completely as possible.

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.

Using the following scale, circle the *most appropriate number* for each situation:

0 = would *less than once a month* doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

Situation	Chance of Dozing
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting, inactive in a public place (in a theatre or in a 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 the traffic	0 1 2 3
	Total: _____/24

1) Are your sleep problems affecting your quality of life? ☐ Yes ☐ No

If yes, is this effect: ☐ mild ☐ moderate ☐ severe

Memory Problems? ☐ Yes ☐ No
Problems Concentrating? ☐ Yes ☐ No
Irritability? ☐ Yes ☐ No

2) Because of your sleep problems, have you:

Considered (or are on) disability? ☐ Yes ☐ No
Had work (or school) difficulties? ☐ Yes ☐ No
Had motor vehicle accidents? ☐ Yes ☐ No
Had driving problems? ☐ Yes ☐ No

3) Do you feel rested when you awaken for the day? ☐ Yes ☐ No

4) Do you feel that you are more tired during the day than you should be? ☐ Yes ☐ No

5) Do you get strong urges to fall asleep during the day? ☐ Yes ☐ No

6) Do you fall asleep unintentionally during the day? ☐ Yes ☐ No

If yes, does this occur while you are:

Inactive or bored? ☐ Yes ☐ No
Active or engaged in interesting activities? ☐ Yes ☐ No

7) Do you nap during the day? ☐ Yes ☐ No

If yes: How often? _____ times per day/week/month.
How long? _____ minutes/hours.

Are the naps refreshing? ☐ Yes ☐ No

8) How many nights a week do you have sleep problems? _____ nights.

9) What time do you go to bed during the week? _____ p.m./a.m.
On the weekend? _____ p.m./a.m.

10) How long does it take you to fall asleep at night? _____ minutes.

11) What time do you get up during the week? _____ p.m./a.m.
What time do you get up on the weekends? _____ p.m./a.m.

12) On average, how often do you wake up during the night? _____ times.
How long does it take you to return to sleep? _____ minutes.

During the <u>past month</u>, how many nights per week did you spend at least one hour awake after falling asleep? ☐ Less than 3 ☐ 3-5 ☐ 6-7

13) How long do you sleep for on an average night? _____ hours.

14) How much sleep do you feel you need? _____ hours.

15) Do you snore? ☐ Do not know ☐ Yes ☐ No
If yes,

A) How often do you snore? (check one)
- ☐ Every night
- ☐ Most (>50%) of nights
- ☐ Some (<50%) of nights
- ☐ Very rarely or not at all

B) How long do you snore? (check one)
- ☐ All night
- ☐ Most (>50%) of nights
- ☐ Some (<50%) of nights
- ☐ Hardly or not at all

C) How audible is your snoring (with the door shut)? (check one)
- ☐ Can be heard down the hall
- ☐ Can be heard in the next room
- ☐ Can be heard in the same room
- ☐ Barely audible

16) Have you awakened during the night choking? ☐ Yes ☐ No

17) Do you ever wake up with an acidic taste in your mouth? ☐ Yes ☐ No

18) Do you ever wake up with your heart racing? ☐ Yes ☐ No

19) On average,
how many times do you get up to go to the bathroom during the night? _____ time(s).

20) Do you awaken in the morning with a dry mouth or cough? ☐ Yes ☐ No

21) Have you gained weight in the last 5 years? ☐ Yes ☐ No
If yes, how much? _____

22) Do you have morning headaches? ☐ Yes ☐ No
If yes, how many days a week? _____ days.

23) Do you have any of the following?

Frequent nasal congestion ☐ Yes ☐ No Tonsillectomy ☐ Yes ☐ No
Blocked nasal passages ☐ Yes ☐ No Nose injury ☐ Yes ☐ No
Previous use of CPAP? ☐ Yes ☐ No False teeth/dentures? ☐ Yes ☐ No
Previous operation for sleep apnea? ☐ Yes ☐ No
Previous use of an oral appliance? ☐ Yes ☐ No

24) Is there a family history of sleep disorders, such as snoring, sleep apnea, narcolepsy, or excessive daytime sleepiness (circle disorder if yes)? ☐ Yes ☐ No

25) Do you take medication or alcohol to sleep better? ☐ Yes ☐ No

26) How many alcoholic drinks do you have on weekdays?_____ on weekends?_____

27) How many caffeine-containing drinks do you consume per day?
____ cups of coffee ____ cola drinks ____ other caffeine drinks

28) Do you smoke? ☐ Yes ☐ No (former smoker) ☐ No (never)
If yes, how much per day? _____ cig./packs.

29) Do you kick during sleep? ☐ Yes ☐ No
Does your body jerk during sleep? ☐ Yes ☐ No

30) Do you have uncomfortable leg sensations (burning, aching, creeping, crawling), that gets worse with rest and better with movement resulting in a need to move your legs? ☐ Yes ☐ No
If yes, do these sensations interfere with your sleep? ☐ Yes ☐ No

This occurs: ☐ every night ☐ 3-5 times/week ☐ 1-2 times/week ☐ less than once/week

31) Have you ever felt "paralyzed" while falling asleep or waking up? ☐ Yes ☐ No

32) Have you ever had vivid dreams or "hallucinations" while falling asleep or waking up? ☐ Yes ☐ No

33) Have you ever collapsed, or lost muscle strength? ☐ Yes ☐ No
If yes, did these episodes come on after experiencing a sudden emotion such as anger, joy or surprise? ☐ Yes ☐ No

34) Do you have nightmares or terrifying experiences at night? ☐ Yes ☐ No

35) Do you talk in your sleep? ☐ Do not know ☐ Yes ☐ No

36) Do you sleep-walk? ☐ Yes ☐ No

37) Has anyone observed you to have unusual movements or behavior in your sleep? ☐ Yes ☐ No

38) Do you eat in your sleep? ☐ Yes ☐ No

Patient Medical History

Have you ever been diagnosed with: (Please √ Yes or No)

				On Medications for:	
A.	High blood pressure?	☐ Yes	☐ No	☐ Yes	☐ No
	Atrial fibrillation?	☐ Yes	☐ No	☐ Yes	☐ No
	Arrhythmia?	☐ Yes	☐ No	☐ Yes	☐ No
	Pacemaker?	☐ Yes	☐ No	☐ Yes	☐ No
	ICD?	☐ Yes	☐ No	☐ Yes	☐ No
	Stroke?	☐ Yes	☐ No	☐ Yes	☐ No
	Shortness of breath?	☐ Yes	☐ No	☐ Yes	☐ No
	Swelling in your ankles?	☐ Yes	☐ No	☐ Yes	☐ No
	Congestive Heart Failure?	☐ Yes	☐ No	☐ Yes	☐ No
	Angina?	☐ Yes	☐ No	☐ Yes	☐ No
	Heart murmur?	☐ Yes	☐ No	☐ Yes	☐ No
	Diabetes?	☐ Yes	☐ No	☐ Yes	☐ No
	High Cholesterol?	☐ Yes	☐ No	☐ Yes	☐ No
	Pre or Post Menopausal?	☐ Yes	☐ No	☐ Yes	☐ No
	Are you pregnant?	☐ Yes	☐ No	☐ Yes	☐ No

Is there a family history of developing heart attacks or strokes in a direct family member less than 50 years of age? ☐ Yes ☐ No

B.	Head injury?	☐ Yes	☐ No		
	Frequent headaches?	☐ Yes	☐ No		
	Epilepsy?	☐ Yes	☐ No	☐ Yes	☐ No
C.	Arthritis?	☐ Yes	☐ No	☐ Yes	☐ No
	Fibromyalgia?	☐ Yes	☐ No	☐ Yes	☐ No
	Do you wake up at night from pain or does it prevent you from falling asleep?	☐ Yes	☐ No	☐ Yes	☐ No
D.	Depression problems?	☐ Yes	☐ No	☐ Yes	☐ No
	Anxiety?	☐ Yes	☐ No	☐ Yes	☐ No
	Panic attacks?	☐ Yes	☐ No	☐ Yes	☐ No
	Psychiatric treatment?	☐ Yes	☐ No	☐ Yes	☐ No
	Alcoholism?	☐ Yes	☐ No		
	Previous Drug Abuse?	☐ Yes	☐ No		
E.	Kidney disease?	☐ Yes	☐ No	☐ Yes	☐ No
	Asthma?	☐ Yes	☐ No	☐ Yes	☐ No
	Emphysema?	☐ Yes	☐ No	☐ Yes	☐ No
	Bronchitis?	☐ Yes	☐ No	☐ Yes	☐ No
	Hypothyroidism?	☐ Yes	☐ No	☐ Yes	☐ No
	Hyperthyroidism?	☐ Yes	☐ No	☐ Yes	☐ No

F. Describe any medical problems not listed on the previous page:

_____

_____

_____

_____

G. List all medicines and pills that you are taking (name/dosage):

_____

_____

_____

_____

_____

_____

H. List any drugs or medicines you are allergic to:

_____

_____

_____

Please return this form to:

SLEEP DISORDER CENTRE

Misericordia Health Centre
99 Cornish Ave
Winnipeg, MB R3C 1A2
Fax back to: 204-779-8657
Telephone: 204-788-8570

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM