PATIENT QUESTIONNAIRE

Name: _____ Date: _____

DOB: _____ Age: _____

☐ Married ☐ Single ☐ Widowed ☐ Common-law ☐ Other _____

For above, how long: _____

☐ Live in House ☐ Apt ☐ Condominium ☐ Other _____

☐ Live(s) with: _____

☐ Occupation/How long: _____

☐ Do you have Pet(s): _____

Do you have a driver's license? ☐ Yes ☐ NO

Reason for referral:

_____

How long has this been happening:

_____

Sleep Pattern: _____

What Time Do You Go to bed: _____

- How Long Does It Take To Fall Asleep: _____
- Do You Wake In The Night? ☐ No ☐ On Occasion ☐ Yes
- Why do you wake: _____
- How Long Does It Take to Fall Back Asleep? _____
- What Time Do You wake up: _____
- Do You Feel Your Sleep Is Refreshing: _____
- Do You Feel Fatigued in The Day: _____
- Do you Nap(s): ☐ No ☐ Yes, How Long Do You Nap: _____

Apnea:

Snoring ☐ No ☐ Yes _____

Dry Mouth ☐ No ☐ Yes _____

Drooling ☐ No ☐ Yes _____

Sweating ☐ No ☐ Yes _____

Headache when you wake ☐ No ☐ Yes

Gasping For Air ☐ No ☐ Yes _____

Stop Breathing ☐ No ☐ Yes _____

Are you on CPAP: ☐ No ☐ Yes

Medical Exam:

Height: (cm) _____ or (ft) _____ BP: _____

Weight: (kg) _____ or (lb) _____ Pulse: _____

BMI: _____ O2 Sat: _____ Neck circumference: _____

Any weight change in past 1 year? ☐ No ☐ Yes _____ lbs ☐ loss ☐ gain

Parasomnia:

☐ Sleep Walk ☐ Talk ☐ Laugh ☐ Cry

☐ Bruxism (teeth grinding) _____

☐ Sleep Eat

☐ Hit ☐ Kick others

☐ Nightmares ☐ Terrors

☐ Strange things others have noticed:

_____

Narcolepsy:

Have you ever wakened & can't move: ☐ No ☐ Yes

Falling asleep in odd situations: ☐ No ☐ Yes

Have you seen or heard things that weren't there when awaking? ☐ No ☐ Yes

Excessive Daytime Sleepiness ☐ No ☐ Yes

RLS/PLMS: _____

☐ Unable to sit/lie while awake

☐ Do Your Legs Stop You from Falling Asleep

☐ Crawling/Itching sensation

☐ Leg Cramps

Social:

Born (city/country): _____

Raised (city/country): _____

Year Immigrated to Canada: _____

Siblings: Brothers _____ Sisters: _____

Parents Alive:

Mom: ☐ Yes (age: ____) ☐ No _____

Dad: ☐ Yes (age: ____) ☐ No _____

Are they Together? ☐ Yes ☐ No

Education: ☐ High School ☐ Trade ☐ College ☐ University _____

☐ Occupation/how long :

_____

☐ Kids: _____/Boy(s) Age(s): _____

_____/Girl(s) Age(s): _____

RESET FORM

Medical History:

Medications:

Allergies: ☐ No ☐ Yes (check all the apply) ☐ **Medication:** _____ ☐ **Food:** _____ ☐ **Other:** _____

Psychiatric History: Have you ever been treated for or been diagnosed with (Check any/all that apply)

☐ **Anxiety** ☐ **Depression** ☐ **ADHD** ☐ **PTSD** ☐ **OCD** ☐ **Mania** ☐ **Paranoia** ☐ _____

How is your mood right now? _____ **Appearance: Thin** ☐ **Avg** ☐ **Over** ☐ **Obese** ☐

Suicidal ideation? ☐ **No** ☐ **Yes** _____

Family History:

Substances

Smoking history: ☐ **Lifetime; never smoked** ☐ **Did, but in the past. How long ago** _____ **How long did you smoke** _____

☐ **Do smoke, how many per/day:** _____

☐ **Do not Drink or Alcohol units** _____ **per:** ☐ **day** ☐ **week** ☐ **month** ☐ **occasional**

☐ **Coffee:** _____/ ☐ **day** ☐ **week** ☐ **month** **Size:** ☐ **Small** ☐ **Regular** ☐ **Medium** ☐ **Large** ☐ **Extra Large**

☐ **Tea:** _____/ ☐ **day** ☐ **week** ☐ **month** **Size:** ☐ **Small** ☐ **Regular** ☐ **Medium** ☐ **Large** ☐ **Extra Large**

☐ **Cola:** _____/ ☐ **day** ☐ **week** ☐ **month** **Size:** ☐ **Small** ☐ **Regular** ☐ **Medium** ☐ **Large** ☐ **Extra Large**

☐ **Energy Drinks: cans per** _____ ☐ **day** ☐ **week** ☐ **month**

- **Marijuana:** ☐ **No** ☐ **Yes, how much and how often:** _____
- **Street Drug Use: (check the boxes for all that applies):**

☐ **Crack** ☐ **Cocaine** ☐ **Heroin** ☐ **Hash** ☐ **Ecstasy** ☐ **Oxycodone** ☐ **Mushroom** ☐ **Fentanyl** ☐ **Crystal Meth**

☐ **other:** _____

Have you been for a sleep test previously?

When: _____

Where:

CPAP: _____

_____

The patient has been instructed to refrain from driving, under any circumstances, when drowsy or otherwise impaired.

Sleep Questionnaire: (OFFICE USE ONLY)

- **Stop Bang:** 0 **/8**
- **ESS Epworth:** 0 **/24-10**
- **PHQ-9:** 0 **/27**
- **GAD-7:** 0 **/21**

General Anxiety Disorder (GAD-7)

NAME _____ DATE _____

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
• Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
• Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
• Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
• Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
• Becoming easily annoyed or Irritable	☐ 0	☐ 1	☐ 2	☐ 3
• Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column	0	0	0	0
TOTAL SCORE *(add your column scores)*	0			
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐ 0	☐ 1	☐ 2	☐ 3

Scoring *Add the results for question number one through seven to get a total score.*

If you score 10 or above you might want to consider one or more of the following:

1. Discuss your symptoms with your doctor,
2. Contact a local mental health care provider or
3. Contact my office for further assessment and possible treatment.

Although these questions serve as a useful guide, only an appropriate licensed health professional can make the diagnosis of Generalized Anxiety Disorder.

A score of 10 or higher means significant anxiety is present. Score over 15 are severe.

GUIDE FOR INTERPRETING GAD-7 SCORES

Scale	Severity
0-9	None to mild
10-14	Moderate
15-21	Severe

GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke. et.al.

Patient Health Questionnaire (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0☐	1☐	2☐	3☐
2. Feeling down, depressed, or hopeless	0☐	1☐	2☐	3☐
3. Trouble falling or staying asleep, or sleeping too much	0☐	1☐	2☐	3☐
4. Feeling tired or having little energy	0☐	1☐	2☐	3☐
5. Poor appetite or overeating	0☐	1☐	2☐	3☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0☐	1☐	2☐	3☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0☐	1☐	2☐	3☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0 ☐	1☐	2☐	3☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	0☐	1☐	2☐	3☐

For office coding: Total Score_____ = 0 + 0 + 0

Total Score 0

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Guide for Interpreting PHQ-9 Scores		
Score	Depression Severity	Action
0 - 4	None-minimal	Patient may not need depression treatment.
5 - 9	Mild	Use clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
10 - 14	Moderate	Use clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
15 - 19	Moderately severe	Treat using antidepressants, psychotherapy or a combination of treatment.
20 - 27	Severe	Treat using antidepressants with or without psychotherapy.

Epworth Sleepiness Scale

This scale is used to determine a person's level of daytime sleepiness.

In the following situations, how likely are you to doze off or fall asleep, in contrast to just feeling tired? Use the following scale to choose the most appropriate number for each situation:

0 = would never doze or sleep
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

This refers to your usual way of life in recent times. Even haven't if you haven't done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best as you can.

Situation	Score
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting inactive in a public place	0 1 2 3
Being a passenger in a car for an hour	0 1 2 3
Lying down in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (no alcohol)	0 1 2 3
Stopping for a few minutes in traffic while driving	0 1 2 3
Total Epworth score	0 0 0 0

UNDERSTANDING THE SCORE

0-10: Normal range in healthy adults
11-14: Mild sleepiness
15-17: Moderate sleepiness
18 or higher: Severe sleepiness

Name _____

Height _____ Weight _____

Age _____ Male / Female _____

STOP-BANG Sleep Apnea Questionnaire

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes ☐	No ☐
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	Yes ☐	No ☐
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes ☐	No ☐
Do you have or are you being treated for high blood **P**RESSURE?	Yes ☐	No ☐

BANG		
BMI more than 35kg/m2?	Yes ☐	No ☐
AGE over 50 years old?	Yes ☐	No ☐
NECK circumference > 16 inches (40cm)?	Yes ☐	No ☐
GENDER: Male?	Yes ☐	No ☐

TOTAL SCORE	0	

High risk of OSA: Yes 5 - 8

Intermediate risk of OSA: Yes 3 - 4

Low risk of OSA: Yes 0 - 2