WELL Health | DIAGNOSTIC CENTRES
Previously MyHealth | CENTRE

Brampton Sleep Disorders Centre
34 - 480 Chrysler Dr Tel: (905) 790-8800
Brampton, ON L6S 0C1 Fax: (905) 790-6008

PERSONAL INFORMATION

Name:			Date:
Date of Birth (DD-MMM-YY):	Age:	Marital Status:	Sex: ☐ Male ☐ Female
Live in: ☐ House ☐ Apt ☐ Condo	Live(s) with:		
Street Address:			City:
Province:	Postal Code:	Home Phone:	
Work Phone:	Other Phone:	Cell Phone:	
Occupation: **How Long?:**	Employer:	**Presently working as:**	
Education: ☐ High School ☐ Trade ☐ College ☐ University			
Height: feet inches	Weight: lbs	Health Card #:	
Ethnicity: ☐ Caucasian ☐ Asian ☐ African American ☐ Hispanic ☐ Other :_____			
Referring Physician:		Family Physician:	
Other Health Care Providers:		Born in (Country/City): Raised in (Country/City):	
Email:		**Do You Drive: ☐ Yes ☐ No**	

PRIVACY PRACTICE

I wish to be contacted in the following manner (Check ALL that apply)

☐ Home Phone ☐ By text ☐ By email
☐ Cell phone ☐ By fax ☐ Call me at work

Please tell us who may receive any messages about your health information (Check ALL that apply)

☐ Spouse/Significant other. Please list his/her name:_____ Number: _____

☐ Child(ren). Please list his/her name: _____ Number: _____

☐ Other person(s). Please list his/her name:_____ Number:_____

☐ **I DO NOT WANT ANY PERSON(S) to receive any messages about my health information**

Please note that all of your medical reports will be sent to your family/referring physician.

Patient Questionnaire

SLEEP PROBLEMS

☐ Snoring
☐ Gasping / Choking
☐ Witnessed pauses in breathing
☐ Difficulty staying asleep
☐ Fatigue during the day
☐ Sleepiness during the day

Duration of Symptoms: ☐ 1-6 months ☐ 7-12 months ☐ 13-24 months ☐ Greater then 2 years

What treatment(s) have you received for these symptoms:
☐ None ☐ Weight Loss ☐ Sleeping Pill, name_____ ☐ Oral Appliance
☐ CPAP ☐ Other, list: _____

Have you had a sleep test before? ☐ No ☐ Yes, if yes Where:_____ When:_____

Have you gained any weight over the past 2 years?☐ No ☐ Yes If yes, How many pounds? _____lbs
Have you been seen by a dietician? ☐ Yes ☐ No

Do you sleep on your: ☐ side ☐ back ☐ stomach

Do you do shift work? ☐ No ☐ Yes If yes, how long:_____

☐ Day and afternoon ☐ Rotating Day, ☐Afternoon and nights ☐Nights only ☐ Afternoon only

SLEEP ENVIRONMENT

Is your room quiet, dark and cool?	☐ Yes ☐ No If no, please explain:
Is your bed comfortable?	☐ Yes ☐ No
Do you or your partner watch TV in bed?	☐ Yes ☐ No

SLEEP HABIT

	Working Day	**Non-Working Day**
What time to you go to bed?	_____☐ **am** ☐**pm**	_ ___☐ **am** ☐**pm**

On average, how long does it take you to fall asleep?☐ Less than 5 min. ☐ 5-30min. ☐ 30min-1hr ☐ 1-2hr ☐+2hr
Do you have frequent worrisome thoughts, cannot turn off your mind? ☐ Yes ☐ No
If yes, how long: _____year(s) _____ month(s) _____week(s)
Any triggering factors? Please explain: _____

Do you have the urge to move your legswhile sleeping or lying down, improved with getting up, stretching legs orwalking?☐ No ☐ Yes If yes, does it affect sleep? ☐ Yes ☐ No Unable to sit/lie while awake? ☐ Yes ☐ No
Is there a family history for same? ☐ No ☐ Yes If yes, who? _____
Any history of Renal Disease? ☐ Yes ☐ No Iron Deficiency? ☐ Yes ☐ No Anemia? ☐ Yes ☐ No
Excessive coffee intake? ☐ Yes ☐ No Anti-depressant medications? ☐ Yes ☐ No

If you cannot sleep what do you do?

☐ Lie in bed ☐ Watch TV in bed ☐Take sleeping pills ☐ Go to another room to relax ☐ Alcohol drink
☐ Go on phone or computer ☐ Go to separate room and avoid any stimulating activities
Once back asleep, do you stay asleep? ☐ Yes ☐ No
If you wake up, how many times:☐ 1-2 ☐ 3-4 ☐ 5-7
And for how long?☐1-10 min. ☐ 15-20 min. ☐ 20-30 min. ☐ 30-60 min. ☐ longer: _____

Reason for waking up?☐ **washroom** ☐ **Snoring** ☐**Noise** ☐ **Hot flashes**☐ **Spontaneous** ☐**Other:**_____

SLEEP HABITS Continued…….

What time do you get up? Working days:_____ Non-working days: _____

How many hours of sleep do you get during working days: _____ Non-working days:_____

How do you feel on awakening?

☐ Fresh and restored ☐ Dry mouth ☐ Want to go back to sleep
☐ No energy ☐ Generalized aches and pain ☐ Stiffness ☐ Headaches
☐ Drooling ☐ Sweating

Do you ever have sensation of inability to move all your muscles on awakening? ☐ No ☐ Yes, how frequent? _____
When you laugh, get surprised or get angry do your muscles become weak (jaw drooping etc)? ☐ No ☐ Yes
If yes, how often?_____
Before going to sleep or on wakening up, do you hear voices or have visual hallucinations? ☐ No ☐ Yes
Does any member of your family have narcolepsy? ☐ No ☐ Yes
Do you nap during the day-time? ☐ No ☐ Yes
If yes, how long: ☐ 5-20 min. ☐ 21-30 min. ☐ 31-60 min. ☐ 61-120 min.
Do you feel restored after napping? ☐ No ☐ Yes
Have you noted any decline in your memory/executive function? ☐ No ☐ Yes If yes, how long?_____

Do you exercise? ☐ No ☐ Yes, if yes please indicate what exercise you do:
☐ Walk ☐ Gym ☐ Swimming ☐ Treadmill/Running ☐ Biking ☐ Other: _____
Duration: ☐ 10-15 minutes ☐ 15-30 minutes ☐ 31-60 minutes ☐ over 61 minutes

Times per week: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ over 8

Have you been treated for Anxiety / Depression? ☐ No ☐ Yes
If yes, how long? ☐ 6-12 months ☐ 1-2 years ☐ 3-10 ☐ 10 years or more

Have you seen a psychiatrist? ☐ No ☐ Yes If yes, date of last visit? _____
Have you been treated with medication? ☐ No ☐ Yes If yes, what medication: _____
Do you have any homicidal or suicidal thoughts? ☐ No ☐ Yes
As a result of sleepiness have you experienced?
☐ Auto Accident ☐ Poor work performance ☐ Work related injury ☐ Reduction in quality of life

DURING SLEEP

Has anyone told you that you:	Frequently	Occasionally	Never	Don't Know
Snore	☐	☐	☐	☐
Stop Breathing	☐	☐	☐	☐
Grinding of teeth	☐	☐	☐	☐
Sleep walking	☐	☐	☐	☐
Wake up screaming	☐	☐	☐	☐
Eat while asleep	☐	☐	☐	☐
Leg kicking during sleep	☐	☐	☐	☐
Act out in dreams	☐	☐	☐	☐
Talk in sleep	☐	☐	☐	☐
Strange things others have notice**:**_____	☐	☐	☐	☐

SOCIAL & FAMILY HISTORY

Type of work: _____ Do you have siblings?_____

Marital Status: ☐ Married ☐ Common-Law ☐ Single ☐ Divorced ☐ Separated ☐ Partner

Do you have children? ☐ No ☐ Yes If yes, how many kid(s) / Age(s): _____

Mother Alive? ☐ Yes ☐ No, If no, age at death:_____, cause of death: _____
Family history of: ☐ High blood pressure ☐ Diabetes ☐ Heart disease ☐ Restless leg syndrome ☐ Narcolepsy
AGE: _____ ☐ Depression ☐ Parkinson ☐ Obstructive sleep apnea

Father Alive? ☐ Yes ☐ No, If no, age at death: _____, cause of death: _____
Family history of: ☐ High blood pressure ☐ Diabetes ☐ Heart disease ☐ Restless leg syndrome ☐ Narcolepsy
AGE: _____ ☐ Depression ☐ Parkinson ☐ Obstructive sleep apnea

GENERAL HEALTH HISTORY

1. Have you ever been diagnosed with any of the following (please check all that apply):

☐ Allergies/nasal congestion/sinusitis	☐ Diabetes (how long):____	☐ Seizures/Epilepsy
☐ Hyperthyroidism (over-active thyroid)	☐ Emphysema/COPD	☐ Asthma
☐ Hypothyroidism (under-active thyroid)	☐ Congestive heart failure	☐ Arthritis
☐ Heart disease (heart attack, angina)	☐ Kidney disease	☐ Atrial fibrillation
☐ Hypertension (high blood pressure)	☐ Irregular heart beat	☐ High Cholesterol
☐ Head injury	☐ Liver disease	☐ Schizophrenia
☐ Stroke	☐ Anxiety	☐ Panic disorder
☐ Iron Deficiency	☐ Migraine headaches	☐ Fibromyalgia
☐ Depression or Anxiety	☐ Constipation	☐ Erectile Dysfunction
☐ Tonsillectomy	☐ Sinusitis	☐ Surgery for OSA
☐ Bariatric Surgery	☐ Previous CABG	☐ Coronary Artery Disease
☐ Palpitations	☐ Chest Pain on exertion	☐ Short of breath on exertion

2. Any major surgeries or medical conditions not listed?

3. Any menopausal symptoms? ☐ No ☐ Yes If yes, ☐ Hot flashes ☐ Difficulty sleeping ☐ other: ____
How are these symptoms treated?

4. Please list any medications, vitamins, herbs and supplements you have been taking in the last year. Please include both prescription and over-the-counter medications (use back if more space is required):

Medication	**Dosage**	**Frequency**	**Reason**	**Date started**

5. **Please describe any allergies or other adverse reactions to medications**:
☐ None, no known drug allergies ☐ Yes, name of drug and type of reaction:____

6. How many cups of caffeinated beverages (select) do you drink per day: ☐ coffee ☐ tea ☐ pop ☐ energy drinks
☐ None ☐ 1-2 cups ☐ 3-5 cups ☐ 6 or more

7. When do you usually drink your last cup of caffeinated beverage each day?
☐ Before noon ☐ Before 4pm ☐ Before 8pm ☐ Within 1hr of bedtime

8. **Do you smoke cigarettes?** ☐ No ☐ Yes Do you vape? ☐ No ☐ Yes how often?_____
If yes, how many packs per day? ☐ Less than ½ a pack ☐ ½ a pack ☐ 1 pack ☐ 2 packs or more
How Long: ☐ 5-10 years ☐ 10-20 years 21-30 years or more
Have you smoked in the past? ☐ No ☐ Yes, If yes, for how long: _____ How many per/day:_____

9. **How many alcoholic beverages do you have each week on average**?

a. ☐ None ☐ 1-7 drinks ☐ 8-14 drinks ☐ 15 drinks or more

b. What type of alcohol do you mainly drink: ☐ Beer ☐ Wine ☐ Cooler ☐ Spirits

c. Do you have 5 or more drinks on a single day? ☐ Yes ☐ No

d. Each drink contains how many ounces of alcohol? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

e. Have you received counseling to decrease your alcohol intake or advised accordingly? ☐ Yes ☐ No

11. Select all that apply, do you use: ☐ **NONE**
☐ Crack ☐ Cocaine ☐ Heroin ☐ Ecstasy
☐ Oxycodone ☐ Mushroom ☐ Fentanyl ☐ Crystal Meth ☐ other: _____

12. Select all that apply, do you use: ☐ **Marijuana** ☐ **CBT Oils** ☐ **Hash** ☐ **NONE**

FATIGUE SCALE (Please circle the one statement that describes your present energy level):

A	Full of energy: enough to tackle my usual physical activities.
B	Energy level is quite high but not at its peak: most physical activities would pose no problem
C	Energy level is such that one would prefer to be doing very light or sedentary tasks at this point.
D	Energy level is adequate for only routine activities at a leisurely pace.
E	Energy level is such that it would be preferable to rest before doing any routine activity.
F	Energy level is quite low: would strongly prefer to rest than do anything else.
G	Totally physically exhausted: unable to undertake the least activity.

SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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.

Choose the most appropriate answer for each situation:	**High Chance of Dozing**	**Moderate Chance of Dozing**	**Slight Chance of Dozing**	**Would Never Doze**
a. Sitting and reading	☐	☐	☐	☐
b. Watching TV	☐	☐	☐	☐
c. As a passenger in a car for an hour without a break	☐	☐	☐	☐
d. Sitting inactive in a public place (waiting room etc).	☐	☐	☐	☐
e. Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
f. In a car while stopped for a few minutes in traffic	☐	☐	☐	☐
g. Sitting quietly after lunch without alcohol	☐	☐	☐	☐
h. Sitting and talking to someone	☐	☐	☐	☐

What do YOU personally think your sleep problem is?

_____

_____

_____

What are your expectations/hopes from assessment and treatment?

_____

_____

Any other information that you consider of relevance?

_____

_____

How is your mood right now?

_____

Thank you for taking the time to complete this questionnaire.