CONFIDENTIAL PATIENT QUESTIONNAIRE

NAME: .....

DATE OF BIRTH: .....

GENDER: .....

REFERRING DOCTOR: .....

The following information is requested to assist us in giving you the best possible care. All of the information you provide will be treated as strictly confidential.

Try as best you can to answer all questions. If you are certain that a question does not apply to you leave it blank.

If you need help with a question, please ask one of our sleep technicians to explain it during your stay at Southern Sleep.

Section 1

Listed below are some screening questions that will help inform our sleep physicians about your risk factors for obstructive sleep apnea. Please answer each question with either yes/no or by filling out in space provided.

1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? Yes / No
2. Do you often feel tired, fatigued, or sleepy during daytime? Yes / No
3. Has anyone observed you stop breathing during your sleep? Yes/ No
4. Do you have or are you being treated for high blood pressure? Yes / No
5. *What is your current height and weight?* ……
7. Please measure your neck circumference and write it in space provided ……..cm

Section 2

Listed below are hypothetical statements about night and daytime symptoms. Please circle an answer from 1 to 5 that is *most* true for *your situation* using the following scale:

1 = NEVER
2 = RARELY
3 = SOMETIMES
4 = OFTEN
5 = ALWAYS
N/A = Not applicable

1.	My **nose blocks** up when trying to sleep (allergies, infections).	1 2 3 4 5
2.	I wake with a **dry mouth.**	1 2 3 4 5
3.	I wake in the morning with a **headache.**	1 2 3 4 5
4.	I have daytime naps. (Average number per day = ...)	1 2 3 4 5
5.	I suffer from impairment of **memory.**	1 2 3 4 5
6.	I find it difficult to **concentrate.**	1 2 3 4 5
7.	I experience **restless legs,** which stop me from falling asleep.	1 2 3 4 5
8.	I experience or I am told that I **sleep walk**.	1 2 3 4 5
9.	My sleep is disturbed by pain in the neck, back, muscles/joints/legs/arms/chest?	1 2 3 4 5

Section 3

This section asks a number of questions related to your typical sleep habits. Please provide an answer on the dotted line or yes/no:

1. At what time do you usually go to bed on weeknights? .....
2. At what time do you usually go to bed on weekend nights? .....
3. How many night per week do you take something to help you get to sleep? .....

   Please specify what you take .....
   Pleas specify the amount you take .....

4. Do you feel that you typically get enough sleep during the night? Yes/ No
5. How many times do you estimate that you wake up during the night? .....
6. Do you work rotating shifts or unusual times? Please specify .....

Section 4

This section asks questions about some medical and lifestyle factors:

1. Do you **smoke** cigarettes? Yes No
   (Average daily number = ...)
2. If you do not smoke now, have you smoked in the past? Yes No
   (Average daily number =.....)
3. Do you drink **alcohol**? Yes No
   (Average amount = ...)
4. Is your sleep disturbed by pain in the neck, back, muscles/joints/legs/arms/chest? Yes No
5. Do you have any known medical issues related to your breathing or heart? Please specify
   .....

PREVIOUS SLEEP STUDIES:

Please name any other Sleep Centre you have attended and specify any treatment you have received for a sleep problem.

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PLEASE LIST ANY PRESCRIBED OR OVER THE COUNTER MEDICATIONS THAT YOU TAKE:

Medication Name	Daily Dose	What is it taken for?

Signed by:

Please Print Your Name: .....

Signature: .....

Date: .....