Assesment questionnaire nocturnal saturometry

Biron Sleep Care

File N°: _____ Date: _____

Name: _____
Date of birth: _____ Age: _____ Gender: _____
Referring physician: _____
Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ po IMC: _____

Main reason for the physician's consultation : _____

Symptoms

☐ Snoring
☐ Nose breathing issues during nighttime
☐ Frequent nighttime awakenings
☐ Morning headaches
☐ Tiredness during the day
☐ Attention deficit disorder (ADD)
☐ Nose breathing issues during the day
☐ Frequent tonsils infections

Other health problems

_____

Medications

Name	Dosage	Time taken

→ **Section to be completed in the morning following the night ot the test**

1- At what time did the child go to bed? _____
2- At what time did the child fell asleep? _____
3- Did the child woke up during the night? ☐ Yes ☐ No
   If so, how many times? _____
   If so, enter the approximate hours _____
4- Did the child snore during the night? ☐ Yes ☐ No
5- What time did the child wake up this morning? _____
6- Is this night representative of the usual nights ☐ Yes ☐ No

Other relevant information :

_____

_____

In the absence of the completed questionnaires, we are unable to interpret your results.
The questionnaires can be returned by email at bironsommeil@biron.com or when you return the device.

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