Clinical summary Adult

Biron Sleep Care

File N° : _____ Date : _____

Name : _____

Date of birth : _____ Age : _____ Sexe : _____

Profession : _____ Work shift : ◯ day ☐ night

Weight : _____ ◯kg ◯lbs Height : _____ ◯cm ◯ft.in. Neck circ. : _____ ◯cm ◯po BMI : _____

Family physician : _____

MEDICATIONS (names) ☐ list enclosed

PERSONNAL HISTORY

☐ Angina/ Heart attack	☐ Pacemaker	☐ Sleep apnea Apnea Hypopnea Index (AHI) : ____ /h
☐ Stroke (ACV)	☐ Depression	☐ Insomnia
☐ Heart failure	☐ Diabetes	☐ COPD (Chronic Obstrcutive Pulmonary Disease)
→ ☐ Hypertension (known or treated)	☐ Occlusal plate	☐ Asthma
☐ Atrial fibrillation	☐ Others :	

SYMPTOMS

☐ Fatigue (not sleepiness)	☐ Headaches
☐ Non-restorative sleep or restless sleep	☐ Irritability or moods swings, interpersonal difficulties
→ ☐ Observed cessation of breath by entourage	☐ Anxiety
☐ Wake up gasping for air	☐ Decreased motivation, energy or initiative
☐ Get up regularly at night to urinate	☐ Decreased school or work performance
☐ Night sweats	☐ Sleepiness **Score Epworth (see page 2):** _____ **/ 24**
☐ Poor concentration or memory	☐ Others :

LIFESTYLE/ SLEEPING HABITS

Cigarette Smoking	☐ No ☐ yes	Active smoker /old : # years of smoking : _____, # cigarettes / day : __
Vape	☐ No ☐ yes	Active smoker # mg / day : _____
Alcohol	☐ No ☐ yes	Average of drinks / day : _____
Caffeine (Coffee/tea/cola)	☐ No ☐ yes	Average consommations /day : _____
Drugs	☐ No ☐ yes	Types : _____

→ **Do you snore** ? ☐ Don't know ☐ Never or almost never ☐ Sometimes ☐ Often ☐ Always or almost always

Hours of sleep (average) Week : _____ hour/night Between _____h and _____ h Week-end : _____hours/night. Between _____h and _____ h

In what position do you usually sleep (more than one answer is possible): ☐supine ☐ side ☐ prone ☐ I don't know

Do you have trouble falling asleep or staying asleep ? ☐ No ☐ yes **Score ISI (see page 2):** _____ **/28**

→ Are you bothered by **drowsiness during the day** ? *(struggling to stay awake as opposed to manageable tiredness)* ☐ No ☐ yes

Are you **drowsy while driving** ? *(Check only one choice)*

☐ Never ☐ Les than 1 day a month ☐ 1 to 3 days a month

☐ 1 to 3 days a week ☐ 4 to 6 days a week ☐ Every day

Have you had an accident due to drowsiness or fatigue within the past three years? ☐ No ☐ yes

Do you have disconfort in yours legs that prevents you from sleeping ?	☐ No ☐ yes
Have you ever felt a generalized muscle weakness (or felt temporary paralyzed) during a strong emotion such as laughter, anger or surprise?	☐ No ☐ yes
Have you or your bed partner noticed any unusual behavior during your sleep, such as sleepwalking, restless dreaming, or waking confused ?	☐ No ☐ yes

ANY OTHER IMPORTANT INFORMATION :

Complete the questions : Epworth sleepiness scale

What is the possibility of dozing off or falling asleep in these situations? (According to the below scale)	
Scale 0 : Would never 1 : *Slight chance* *2* :Moderate chance *3 : High chance*	
Situations	**Scores**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g theatre, meeting)	
As a passenger in a car for an hour without break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped in traffic for a few minutes	
TOTAL:	**/24**

Complete the questions chart : ISI_Insomnia Severity Index

(To be completed even if you think you do not have insomnia)

A. Select the number that best describes your sleep pattern <u>in the last month</u>					
Scale *0 : None*	*1 : Mild*	*2 : Moderate*	*3 : Severe*	*4 : Extreme*	**Scores**
Problems falling asleep					
Problems staying asleep					
Problems waking up too early in the morning					

B. Estimate the severity that best fits your personal situation					
Scale *0 : Not at all*	*1 : A little*	*2 : Somewhat*	*3 : Much*	*4 : Very much*	**Scores**
How **worried**/distressed are you about your current sleep problem ?					
To what extent do you consider your sleep problem to **interfere** with your daily functionning ? *(eg : daytime fatigue, ability to funtion at work/daily chores, concentration, memory, mood)*					
How **noticeable** to others do you think sleeping problem is in terms of impairing the quality of your life ?					

C. Select the number that described bests your sleep satisfaction.					
Scale *0 : Very satisfied*	*1 : Satisfied*	*2 : Indifferent*	*3 : Unsatisfied*	*4 : Very unsatisfied*	**Scores**
How satisfied are you with your current sleep pattern ?					

(Add all the numbers in section A-B-C of the ISI chart) TOTAL :	**/28**

→ Chart icon = **Stop questionnaire**

- → Snoring
- → Tiredness
- → Observed apnea
- → Pressure (Blood pressure)