Sleep study Pre-exam clinical summary _ Adult

Last Name : ______________________ **First name:** ______________________ **M** ☐ **F** ☐ **Exam Date :** ____________________ YYYY / MM / DD

Date of birth: _________________ YYYY / MM / DD **Age :** ______ **Profession :** ___________________________ **work shift** ☐ day ☐ night

Weight: _______**kg /lbs** **Height:** _______**cm /ft.in.** **Neck circ. :** _______**cm/po** **BMI:** _______

Family physician : ____

Instructions : Complete all sections of the questionnaire including the 2 tables on the back

MEDICATIONS (names) ☐ list enclosed		

PERSONNAL HISTORY	
☐ Angina/ Heart attack	☐ Heart failure
☐ Stroke (ACV)	☐ Asthma, COPD (Chronic Obstrcutive Pulmonary Disease)
☐ Hypertension (known or treated)	☐ Sleep apnea Index **A**pnée **H**ypopnée (AHI) : _______/h
☐ Depression	☐ Insomnia
☐ Diabetes	☐ Others :

SYMPTOMS	
☐ Fatigue (not sleepiness)	☐ Headaches
☐ Non-restorative sleep or agitated sleep	☐ Irritability or moods swings, interpersonal difficulties
☐ Stop breathing observed	☐ Anxiety
☐ Wake up gasping for air	☐ Drop in motivation, energy or initiative
☐ Get up regularly at night to urinate	☐ Poorer school or work performance
☐ Night sweats	☐ Sleepiness **Epworth** : _____ / 24 (see back)
☐ Poor concentration or memory	☐ Other :

LIFESTYLE/ SLEEPING HABITS		
Smoke	☐ No ☐ yes	Active smoker /old : # years of smoking : _____, # cigarettes / day : _____
Alcohol	☐ No ☐ yes	Average of drinks / day : _________
Stimulants(Coffee/tea/cola)	☐ No ☐ yes	Average consommations /day : ____________
Drugs	☐ No ☐ yes	Which one : ____
Do you snore ?	☐ Don't know ☐ Nerver or almost never ☐ Sometimes ☐ Often ☐ Always or almost always	
Hours of sleep (average)	Week : _____ hour/night	Week-end : _____hours/night.
Do you have trouble falling asleep or staying asleep ?	☐ No ☐ yes If yes, score **ISI** : _____ (see back)	
Are you bothered by **drowsiness during the day** ? *(want to sleep or struggle to stay awake and not just be tired)*	☐ 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 days

Do you have disconfort in yours legs that prevents you from sleeping ?	☐ No ☐ yes
Have you ever felt a brief decrease in your muscle strength (or felt temporary paralyzed) when experiencing an emotion such as joy, anger or surprise ?	☐ No ☐ yes

Any other important information :

____

____

Complete the questions : Epworth sleepiness scale

What is the possibility of dozing off or falling asleep in these situation ? (According to the proposed legend)

Legend : 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 **in the last month***	**Results**

Legend : **0 : None** **1 : Mild** **2 : Moderate** **3 : Severe** **4 : Extreme**

Problems falling asleep	
Problems staying asleep	
Problems waking up too early in the morning	
B. *Estimate the severity that best fits your personal situation*	

Legend : **0 : Not at all** **1 : A little** **2 : Somewhat** **3 : Much** **4 : Very much**

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 du you think sleeping problem is in terms of impairing the quality of your life ?	
C. *Select the number that described bests your sleep **satisfaction.***	

Legend : **0 : Very satisfied** **1 : satisfied** **2 : indifferent** **3 : Unsatisfied** **4 : Very unsatisfied**

How **satisfied** are you with your current sleep pattern ?	
(Add all the numbers in section A-B-C of the ISI chart) **TOTAL :**	**/28**

Completed questionnaires must be returned with equipment

In case of forgetfulness, the questionnaires can be returned by email : BSSportail.diagnostic@biron.com