Richmond Hill SLEEP AND LUNG INSTITUTE

Patient Information Form

Please respond *by **filling in the blank space*** or ***circling*** the answer that most closely applies to you.

Patient Name: _____ **Study Date**_____/_____/_____
Last Name *First Name* *m* *d* *y*

Home Address: _____ **Occupation**: _____

City: _____ **Postal Code**: _____ **Do you work Shifts?** YES / NO

Telephone # ( ) _____ ( ) _____ **Date of Birth**: _____/_____/_____
Home *Work* *m* *d* *y*

Health Card Number _____ ***Version Code***: _____ **Age**: ___ **Gender: M / F**

Your Name on Health Card: _____ **Weight:** _____ lbs. **Height:** _____in

Marital Status: Single □ Divorced □
Married □ Common Law □
Separated □

In Case of emergency- ***Notify***: _____ **Phone (** **)** _____

Relation to Patient: _____ **Address:** _____

Your Family Doctor: _____ **Phone (** **)** _____

Address: _____

Do you have a history of:

a) **Y/ N** High Blood Pressure
b) **Y/ N** Epilepsy
c) **Y/ N** Respiratory Disease If yes, what kind: _____
d) **Y/ N** Heart Disease If yes, what kind: _____
e) **Y/ N** Head injury If yes, describe When and How _____
Did you lose consciousness? **Y/ N** _____

Do you have, or are you currently under medical treatment for any of the following?

a. Diabetes…… ……...**Y/ N**
b. Depression…… **Y/ N**
c. Fibromyalgia / Chronic Fatigue Syndrome…..**Y/ N**
d. Arthritis……**Y/ N**
e. Hyperthyroid……**Y/ N**
f. Tinnitis (ringing in the ear)...**Y/ N**
g. Any kind of infection?.....**Y/ N**……
h. Any other condition? .....

How much do you:

Drink **Alcohol**	Drink **Caffeine**	Smoke **Tobacco**
Beer Wine Liquor	Coffee Tea, Soft Drinks	Cigarettes
_____	_____	_____ _____

Please list all medications that you are currently taking, including the ones you will take tonight.

Medication Name	Dosage (mg) # of times	Will take tonight?

Sleepiness

How likely are you to doze off or fall asleep in the following situations. This refers to your usual way of life in recent times. Even if you have not done some things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0=	1=	2=	3=
Would never doze	**Slight chance of dozing**	**Moderate chance of dozing**	**High chance of dozing**

Situation	**Chance of Dozing**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g. theatre, meeting)	_____
As a passenger in a car without a break	_____
Lying down in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car while stopped for a few minutes in traffic	_____
Total:	{ }

Sleep Behavior

- Has today been an unusual day for you? Y/N If yes, please describe_____
- Do you have any physical complaints right now? Y/N If yes, please describe_____
- What is your usual bed-time? _____
- How long does it take you before you go to sleep? _____
- How many hours do you sleep per night, on average? _____
- How much sleep did you have last night? _____
- Would you describe your sleep as …… ***Interrupted / Uninterrupted?***
- Have you gained or lost weight recently? If so, how much _____***GAIN*** *or* ***LOSS***
- Are you experiencing: ***Forgetfulness / Memory Loss / Trouble Concentrating***
- **Y / N** Do you regularly take sleeping pills to help you fall asleep?
- **Y / N** Do you know, or has anyone told you, that you snore?
  If so, is there a family history of loud snoring (grandparents/ parents/ siblings)
- **Y / N** Do you feel sleepy or drowsy during the day? _____
- **Y / N** Do you know whether you periodically stop breathing during sleep?
  If so, is there a similar family history (grandparents/ parents/ siblings)? _____
- **Y / N** Do your legs twitch or jerk at night during your sleep?
- **Y / N** Do your legs feel restless whenever you sit down, or lie down, causing you to get up and walk around?
- **Y / N** Do you think you dream while asleep?
- **Y / N** Do you experience frequent nightmares or night terrors?
- **Y / N** Do you know whether you grind your teeth during your sleep?
- **Y / N** Did you nap today? If YES, how long did you nap for? _____
- **Y / N** Do you have frequent headaches?
  If yes, when? ***Morning / Afternoon / Evening /During the night***

Briefly describe your average night's sleep:

_____
_____
_____
_____
_____
_____
_____
_____

If you do not understand any questions, please ask the attending Sleep Lab Technologist.

Thank you!