MINDS
Mississauga Institute of Neurological Disorders and Stroke

Unit #9, 2145 Dunwin Drive
Mississauga, Ontario L5L 4L9

Phone: (905) 896-3000
Fax: (905) 896-8906
Website: www.mindsneurology.com

HOME SLEEP STUDY REQUISITION & PRE-TEST QUESTIONNAIRE

PATIENT INFORMATION

Last Name:	First Name:	Gender: □ Male □ Female
Date of Birth (DD/MM/YYYY):	Home #:	Cell #:
Health Card #:		
□ OHIP □ Private Pay □ Motor Vehicle Accident		□ Emergent □ Urgent □ Non-Urgent

A) Use the scale below to choose the most appropriate number for each situation, then sum the total score.

0 = would NEVER doze 1 = SLIGHT chance of dozing 2 = MODERATE chance of dozing 3 = HIGH chance of dozing

Situation:

Sitting and reading
Watching TV
Sitting inactive in a public space
As a passenger in a car for an hour
Laying down in the afternoon
Sitting and talking to someone
Sitting quietly after lunch (no alcohol)
In a car and stopped for a few minutes

Total Score:

B) Please choose the appropriate response to each question.

1.	**Do you snore?**	□ Yes □ No □ Don't know	
2.	**If you snore, your snoring is:**	□ Slightly louder than breathing □ As loud as talking □ Louder than talking □ Louder than talking (can be heard in adjacent rooms)	
3.	**How often do you snore?**	□ Nearly everyday □ Never or nearly never	□ 3-4 times a week □ 1-2 times a week □ 1-2 times a month
4.	**Has your snoring bothered other people?**	□ Yes □ No □ Don't know	
5.	**Has anyone noticed that you quit breathing in your sleep?**	□ Nearly everyday □ Never or nearly never	□ 3-4 times a week □ 1-2 times a week □ 1-2 times a month
6.	**How often do you feel fatigued or tired after you sleep?**	□ Nearly everyday □ Never or nearly never	□ 3-4 times a week □ 1-2 times a week □ 1-2 times a month
7.	**During your waking time, do you feel tired, fatigued, or not up to par?**	□ Nearly everyday □ Never or nearly never	□ 3-4 times a week □ 1-2 times a week □ 1-2 times a month
8.	**Have you ever fallen asleep or nodded off driving a vehicle?**	□ Yes □ No	
9.	**If yes to question 8., then how often does this occur?**	□ Nearly everyday □ Never or nearly never	□ 3-4 times a week □ 1-2 times a week □ 1-2 times a month
10.	**Do you have high blood pressure?**	□ Yes □ No □ Don't know	

C) Please check all that apply.

Sleep symptoms:

□ Frequent bathroom visits nightly
□ Gasping, choking, or snorting during sleep
□ Restless legs
□ Limbs jerking/twitching at night
□ Morning headache
□ Insomnia
□ Restless sleep
□ Memory loss
□ Teeth grinding/clenching
□ Waking up paralysed
□ Audible or visual hallucinations around sleep
□ Family history of sleep apnea

Previous sleep diagnoses & treatment:

□ Overnight anxiety
□ MediByte/Type 3 test
□ Sleep study in lab
□ CPAP/BiLevel therapy
□ Dental splint for snoring or OSA

Health issues:

□ Heart disease
□ Stroke
□ COPD
□ Other lung disease
□ Gastric acid reflux
□ Chronic pain
□ Fibromyalgia
□ Diabetes
□ High blood pressure
□ Previous oral/nasal surgery (if yes, please describe: _____)
□ Oxygen use
□ Pacemaker
□ Depression
□ Erectile dysfunction
□ Alcohol consumption (□ daily □ 3-5 times weekly □ weekly □ weekends □ special occasions)
□ Others (please specify: _____)

Medications:

REFERRING PHYSICIAN INFORMATION

Name:	Billing Number:
Phone:	Fax:
Copies to:	