Confidential Pre-Consultation Questionnaire

Please fill out this Form and Fax it to 905-886-9618

PERSONAL INFORMATION

PATIENT CONTACT / HEALTH INFORMATION		
Name:		
DOB (DD/MM/YY): / /		
Health Card:		Version Code:
Email:		
Telephone - Primary:		Secondary:
Address:		City Postal Code
☐ M ☐ F	Age:	Occupation:

FAMILY PHYSICIAN CONTACT INFORMATION:	
Family Doctor:	
Address:	City Postal Code
Telephone:	Fax:
Email:	
Other Physicians who should be informed about your sleep assessment (include Names and Addresses):	

GENERAL QUESTIONS

Please answer the questions to the best of your abilities

Please briefly describe your current sleep difficulty, concern, or other problem:	
Please list all medications you are taking and the doses:	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.
Are you allergic to any medications? ☐ Yes ☐ No If Yes, Please List:	
Past Medical History:	
Hypertension ☐	Stroke ☐
Diabetes ☐	Chronic Pain ☐
Heart disease ☐	Fibromyalgia ☐
Other Medical Conditions: Please Specify	

HEALTH HABITS & PERSONAL SAFETY QUESTIONS

Please answer the questions to the best of your abilities

On average, how much alcohol do you drink per week? (If less than 1 drink per week, write 0)
Cans of Beer: _____ Glasses of Wine: _____ Ounces of Liquor: _____
On average, how much caffeine do you take in each day?
Cups of Coffee: _____ Cups of Tea: _____ Cans of Cola: _____ Slabs of Chocolate: _____
Do you currently smoke cigarettes? ☐ Yes ☐ No If Yes, approx. How many cigarettes per day? _____

EPWORTH SLEEPNESS SCALE

How Likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

0 = would **never** doze
1 = **slight** chance of dozing
2 = **moderate** chance of dozing
3 = **high** chance of dozing

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (e.g. in a theatre; in a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
	Office use only:			

Have you experienced recurring unpleasant sensation or tingling in your legs while sitting or lying down?	☐ Yes ☐ No
If **yes**, how would you describe this sensation? **a)** Painful ☐ **b)** Unpleasant ☐ **c)** Both painful & unpleasant ☐	
Do your legs jump or move involuntarily while sitting or lying down?	☐ Yes ☐ No
If **yes**, how often do these involuntary movements occur? (Please select one answer) **a)** Seldom ☐ **b)** Occasionally ☐ **c)** Frequently ☐ **d)** Almost always ☐	
Do you think the sensations in your legs and the movements are connected?	☐ Yes ☐ No
Do these involuntary movements occur only before you fall asleep?	☐ Yes ☐ No
If these sensations or movements are present and you get up to walk, do they improve or disappear while you are walking?	☐ Yes ☐ No
If **yes**, do they get worse again when you stop walking?	☐ Yes ☐ No

When laughing or if suddenly excited, do you suddenly lose muscle control or strength in your face, arms, and/or legs?			☐ Yes ☐ No
On occasion, do you awaken soon after going to sleep or in the morning actually feeling paralyzed, unable to move or unable to talk, which lasts only a few seconds or minutes?			☐ Yes ☐ No
Are your dreams so real you cannot tell if you are asleep or awake?			☐ Yes ☐ No
Do you talk in your sleep?	☐ Yes ☐ No	Do you grind your teeth while asleep?	☐ Yes ☐ No
Do you sleepwalk?	☐ Yes ☐ No	Do you have frequent nightmares?	☐ Yes ☐ No
Do you experience episodes of extreme terror or screaming during sleep, yet have little or any recollection of the event?			☐ Yes ☐ No
While asleep, have you ever acted out a dream and injured yourself or a bed partner?			☐ Yes ☐ No
Do you eat in your sleep? (This is not concerning dreams)			☐ Yes ☐ No
Have you experienced or been observed to have any other unusual behaviour while asleep?			☐ Yes ☐ No

What time do you usually go to bed?		What time do you usually get up?	
How many times per night do you typically awaken?		How long does it typically take you to fall asleep (in minutes)?	
Approximately how many hours of sleep do you get most nights?		How many hours of sleep would you like to get each night?	
Typically, how many naps do you take per week?		Typically, how long are your naps (in minutes)?	
Are your naps refreshing for you?		Do you dream during your naps?	