Melatonin replacement and sleep program

This questionnaire will take approximately 10 minutes to complete. The information you provide is very important and will assist our sleep specialists during the review of your sleep symptoms. This questionnaire has been compiled based on many years of accumulated experience in Sleep Medicine. The information will be treated with the utmost discretion and will not be used by any party other than Finlandia Pharmacy & Natural Health Centre. Please respond to all questions by completing the free text sections. If you have a bed partner, a parent or guardian, or otherwise someone who is willing to and is able to comment on your sleep patterns or behaviors during sleep please have them complete the "BED PARTNER, PARENT OBSERVATION QUESTIONNAIRE" at the end.

Patient name:

Scheduled Appointment Date:

Phone Nr.:

Sleep Specialist:

Email:

Today's Date:

Height (inches):

DOB:

Weight now (lbs):

Age:

Weight 1 year ago:

Sex:

Weight 5 years ago:

I was referred by:

Name of Doctor:

Sleep schedule

How long have you had sleep problems? Weeks, months, years? _____

Why do you think you can't sleep? _____

What time do you go to bed on weekdays? _____

What time do you go to bed on weekends? _____

What time do you get out of bed on weekdays? _____

What time do you get out of bed on weekends? _____

Do you go to bed every day at the same time?
(Including weekends) _____

How much sleep do you get on an average night (hours)? _____

Are you a morning type, evening type, neither? _____

What would be your ideal bedtimes? _____

Do you have periods of tiredness throughout the day? _____

Do you nap? How often do you nap? (number of times per week) _____

How long are the naps? (in minutes) _____

Do you awaken refreshed from the nap? _____

What are your usual work hours? _____

Are you a shift worker? _____

Do you travel often? If so are you exposed to jet leg? _____

Do you have difficulty falling asleep? _____

Do you have difficulty staying asleep? _____

How fast do you fall asleep? _____

Do you wake up too early and cannot get back to sleep? _____

How many times do you wake up during the night? _____

How long does it take you to fall asleep again? _____

Do you sleep walk? _____

Snoring/Breathing history

Do you snore? _____

What is your preferred sleep position? _____

Back (% of sleep time)? _____

Left Side (% of sleep time)? _____

Right Side (% of sleep time)? _____

Stomach (% of sleep time)? _____

Does your sleep position affect your snoring? _____

Do you awaken with a snort, choking or gasping for air? _____

Do you awaken with a headache? _____

Has anyone noticed you stop breathing while asleep? _____

Do you awaken often to urinate during the night? _____

Do you awaken with acid or sour taste in your mouth? _____

Do you have difficulty breathing while on your back? _____

Do you sweat excessively during the night? _____

Do you awaken with a dry mouth or sore throat? _____

Abnormal movements/behaviors

Do you have or have you ever experienced (Y/N): _____

An urge to move your legs, usually accompanied by uncomfortable and unpleasant sensations in the legs? _____

Discomfort in the legs that worsen during periods of rest or inactivity such as laying down or sitting? _____

Discomfort in the legs that is relieved by movement: walking or stretching? _____

Discomfort that worsens during the nighttime? _____

Do you get cramps at night? _____

Do you kick or jerk your arms or legs during sleep? _____

Are your bed covers messy in the morning? _____

Do you kick, punch, or poke your bed partner while asleep? _____

Have you ever injured your bed partner or yourself? _____

Do you grind your teeth? _____

Do you wear a bite splint (mouth guard)? _____

Do you walk in your sleep? If yes, when was the last time? _____

Do you talk in your sleep? _____

Do you have nightmares or night terrors? _____

Do you make rolling movements or bang and twist your head at night? _____

Have you had sleep problems as a child? _____

Sleeping room conditions

Do you read in bed? Paper copies or electronically? _____

Do you share the bed with anyone? _____

Does your partner have a sleep disorder? _____

Do you have pets sleep in the bedroom? _____

Is your bedroom comfortable? _____

Do you sleep in a completely dark bedroom?
Blacked out windows? _____

What types of lighting do you use? (LED, incandescent, fluorescent) _____

What is your bedroom's temperature? _____

Nutrition

How much water do you drink per day?
When do you drink water? _____

Do you drink any sugary drinks?
If yes, at what times and how close to going to bed? _____

Do you consume any sugary foods?
If yes, at what times and how close to going to bed? _____

When do you eat your evening meals? _____

What's a typical evening meal look like? _____

Do you snack on anything else before you go to bed?
If yes, how long before you go to bed? _____

Medications

List current medications (name, dose, and number taken per day), including OTCs, vitamin/herbal supplements and homeopathics:

Please also include any sleep remedies if applicable. _____

Have you ever used other sleep medications before?
If yes which and what results were obtained with each? _____

Do you take any of the following?
Antihistamines, alpha/beta blockers, or antidepressant? _____

Stress levels and dreams

Are you stressed at home or at work? _____

Do you meditate or have quiet times alone?
If so how much per day or week? _____

Do you have fulfilling relationships (family, spouse, friends)? _____

Do you have thoughts racing through your mind that make it difficult to sleep? _____

Do you know about geopathic stress? _____

Do you dream? If yes, are your dreams pleasant or disturbing? _____

Do you remember your dreams?
Do you remember at what time you dream? _____

Electrical devises

How often do you use electronics devices (i.e. cell phones, tablets, TVs)? (hours per day) _____

Do you have any electronics devices in your bed room? _____

Do you use any electronics devices (i.e. cell phones, tablets, TVs) within 2 hours of going to sleep? _____

Are you exposed to any other EMFs (electromagnetic fields) while sleeping? (i.e. smart meters, WIFI, Bluetooth, cell phone signals, alarm clock, power lines nearby) _____

Other factors

Do you use tobacco products? If yes, how often per day? _____

Do you drink alcohol? If yes, how often per week? _____

Do you drink caffeinated beverages?
If yes, what type and how often per week? _____

Do you use recreational drugs? (i.e. marihuana)
If yes, what type and how often per week? _____

Do you exercise? _____

Do you get regular exercise? Is yes, what type of exercise?
Level of intensity? And how often? _____

Do you have any medication or environmental allergies?
(pets, pollen, food, dust, etc.) _____

Bed partner, parent observation questionnaire

Do you live with the patient? _____

Do you sleep in the same room as the patient? _____

If no, is it because of his/her sleep behaviors (i.e. snores too loud acts out dreams, etc)? _____

Check any of the following behaviors that you have observed the patient is doing while asleep and describe in detail. Include a description of the activity, the time during the night when it occurs, frequency during the night and whether it occurs every night.

- ☐ Waking up at night
- ☐ Waking up too early and cannot get back to sleep
- ☐ Irregular bed times
- ☐ Snoring
- ☐ General emotional instability
- ☐ Pauses in breathing
- ☐ Sleep-talking
- ☐ Sleep-walking
- ☐ Turbulent dreams
- ☐ Unhealthy lifestyle

Please print the questionare with the folowing button and send it per fax to: 604.733.5340

Or save it after you're finish and send it per email to: customerservice@finlandiahealth.com

Print