Medigas
Manitoba Limited
RESPIRATORY WELLNESS CENTRE

150 McPhillips St., Winnipeg, MB R3E 2J9
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HOME SLEEP TEST QUESTIONNAIRE

Please complete this form and return it with your home sleep test device.

PATIENT INFORMATION	
Last Name:	**First Name:**
Phone Number:	**Date:**

1. Why did you require a home sleep test? (check all that apply)

☐ Snoring ☐ Morning headaches ☐ Stop breathing
☐ Unrefreshing sleep ☐ Nighttime heartburn ☐ Always tired

2. What is your medical history? (check all that apply)

☐ High blood pressure ☐ Low thyroid ☐ Diabetes
☐ Heart problems ☐ Depression

Other:

Epworth Sleepiness Scale

How likely are you to fall asleep in the following situations – in contrast to feeling just tired? Answer using the rating scale below, keeping in mind what you consider to be your "usual way of life" in recent times.

Chance of Falling Asleep Rating Chart			
Never	**Slight Chance**	**Moderate Chance**	**High Chance**
0	1	2	3

Situation	Your Rating (Insert 0 to 3)
Sitting and reading	
Watching TV	
Sitting inactive in a public place (i.e. movie theatre, meeting, etc.)	
Sitting as a passenger in a car for a one-hour drive with no break	
Lying down in the afternoon (when circumstances permit)	
Sitting and talking to someone	
Sitting quietly after a lunch without consuming alcohol	
Driving a car in traffic when stopped for a few minutes	

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HOME SLEEP TEST FEEDBACK

1. Did you have any difficulty putting on the equipment? ☐ Yes ☐ No

   If yes, why?

2. Did you find it easy to start your sleep test study? ☐ Yes ☐ No

   If no, why?

3. Did any of the sensors stop you from falling or staying asleep? ☐ Yes ☐ No

   If yes, which one(s) and why?

4. During the sleep test:
   a) What time did you go to bed?
   b) How long did it take for you to fall asleep?
   c) What time did you get out of bed?
   d) Was this a normal sleep for you? ☐ Yes ☐ No

      If no, why?

5. Do you have any suggestions to improve this test?

Thank you for your feedback!