Dr. John L. Corbett
Sleep Physician

Dr. Sean L. Tolhurst
Sleep Physician

CONFIDENTIAL PATIENT QUESTIONNAIRE

The following information is requested to comply with National Privacy Principles, to ensure that you are correctly identified in our records, and to assist us in giving you the best possible care. All of the information that you provide will be considered as being strictly confidential. If you do not understand any question, please ask one of our staff to explain it.

Please write in black ink pen and bring the completed questionnaire with you to your sleep-study

Title: ________ **Name:** ____ **Age:** ________

Date of Birth: ________________________ **Marital Status:** ________________________

Home Address: ____

____ **Post Code:**______________

Postal Address (if different from above): ____

Email Address: ____

Occupation: ____

Phone (Home): ______________ **Phone (Work):** ____________ **Phone (Mobile):** ______________

Emergency Contact Details (name and day/night-time telephone numbers): ____________________

____

Referring Doctor's Name and Address: ____

General Practitioner (if different from above): _____________________________________

Specialists you are currently seeing: ____

____

Medicare Number: ________________________ **Expiry Date:** ____________**Ref No.:** _____

Health Fund: ______________________**Membership No** ______________________

Are you a War Veteran? _____ **Veteran's Affairs Entitlement No.:** ______________ **Gold Card?** ________

Do you hold a Commercial Drivers License that you use for work purposes: Yes/No

I hereby consent to: a polysomnographic sleep study and video recording of myself during the study, follow-up contact(s) from SNORE Australia, and my medical details and sleep report(s) being released to my referring medical practitioner(s) and to any other medical professional(s) to whom I am referred in the future. I also give consent for SNORE Australia to obtain my medical records from other health professionals.

Signed: ______________________________________ **Date:** ________________________

Permission to be Contacted in Relation to Research Projects Related to Sleep Disorders

I have been informed by staff at SNORE Australia of the fact that a number of research studies are being planned by SNORE Australia in relation to sleep disorders. Whilst I am not agreeing to participate in any such research study, I hereby give consent for staff of SNORE Australia to contact me in the future and to pass on the details of specific research studies so that I may then consider whether or not I wish to participate.

Patient Signature: ____________________________ **Date:** ________________________

Witness Name: ________________________________ **Witness Signature:** __________________

Witness Address: ____

INSTRUCTIONS

Please answer every question, unless you are certain that a question does not apply to you, in which case leave it blank. Please circle your answers and write any additional comments where necessary.

SCALE: 0 = Never 1 = Sometimes 2 = Usually 3 = Always

Sleepiness

Do you wake **unrefreshed**?	0	1	2	3
Do you have significant problems with **memory** and/or **concentration**?	0	1	2	3
Is your **driving** affected by excessive daytime sleepiness (e.g., dozing at lights, running off road)?	0	1	2	3
Is your work or occupation affected by daytime sleepiness?	0	1	2	3

Details: ____

Do you have **daytime naps**? Average daily number of naps: ________ Total nap hours per day: ____________

Sleep Disordered Breathing

Do you **snore** in your sleep?	0	1	2	3
Does your snoring **disturb your partner**?	0	1	2	3
Does your snoring cause your partner to **sleep in another room**?	0	1	2	3
Do you wake with a **dry mouth**?	0	1	2	3
Do you wake **gasping for breath or choking**?	0	1	2	3
Have you been told that you **stop breathing** when you are asleep?	0	1	2	3
Do you wake up in the morning with a **headache**?	0	1	2	3
Do you need to **urinate** during the night? (Average number: ___________)	0	1	2	3

Sleep Habits

Do you drink **stimulant drinks** (tea, coffee, cola, energy drinks) during the day? Average daily number: _________

At **what time** do you usually drink your last stimulant drink? ______________________________

At what time do you usually **retire to bed**? ______________________________

At what time do you usually **rise in the morning?** ______________________________

How many **total hours of sleep** do you get during the night? ______________________________

Do you feel that you get **enough sleep on a typical night**? ☐ Yes ☐ No

Do you feel that you have **insomnia** (significant difficulties getting to and/or staying asleep)? ☐ Yes ☐ No

How long does it take you **to get to sleep** at night? ______________________________

Do you have **long wakeful periods** during the night that are a problem? Total hours awake: _________________

If yes, explain why: ____

____

Are you a **shift-worker** (please give details)? ______________________________

____

Sleeping Position

Do you have a **preferred sleeping position**? ☐ Side ☐ Front ☐ Back ☐ None

Would you be **able to sleep exclusively on your side** if this could help your sleep? ☐ Yes ☐ No

If not, please explain why: ____

Restless Legs

Do you get an **irresistible urge to move your legs** or **uncomfortable sensations** in your legs when you sit down and relax at the end of the day or when you retire to bed at night? 0 1 2 3

Is the urge to move your legs **partially or totally relieved by moving** them? ☐ Yes ☐ No

Do you get **numbness or "*pins and needles*"** sensations in your hands or feet? ☐ Yes ☐ No

What treatment have you received (if any)? ______________________________

Additional comments: ____

____

General Medical History (please *circle* any of the following conditions you have and provide additional information where appropriate, including when the condition was diagnosed and what treatment(s) you have received)

Alcohol

How often do you **drink alcohol?** ☐ Never ☐ Special occasions only ☐ ____ nights per week

How many **standard drinks** do you normally have per night? Minimum: ____ Maximum: _____ Average: _______

(A "standard drink" is one 285ml glass of standard beer, two 285ml glasses of light beer, or one small 100ml glass of wine)

Body Height and Weight

What is your current **body weight**? ____________kg What is your current **height**? __________cm

Heart and Circulatory Conditions: heart attack (myocardial infarction), heart failure, ischemic heart disease/angina, atherosclerosis, cardiac bypass surgery, cardiac angioplasty (stent), peripheral oedema, right heart failure, valve replacement, palpitations, cardiac arrhythmia (e.g., atrial fibrillation, SVT, ectopy), cardiac pacemaker

Details: ____

Have you had an **echocardiogram** performed recently? ☐ Yes (where: ______________) ☐ No

Do you have **high blood pressure**? ☐ Yes ☐ No ☐ Medicated

Do you have **high cholesterol** and/or **high blood fats**? ☐ Yes ☐ No ☐ Medicated

Lung and Breathing Disorders: obstructive lung disease (e.g., COPD, asthma), chest wall disease (e.g., kyphoscoliosis), hypercapnic respiratory failure (increased CO_2), emphysema, other lung disorder (please specify):

Details: ____

Have your **tonsils** and/or **adenoids** been removed? ☐ Yes ☐ No

Does your **nose regularly block** at night? ☐ Yes ☐ No

Do you **smoke**?
☐ Current smoker (number per day: __________) What do you smoke? ______________
☐ I have previously smoked but now ceased (age started: _____ age ceased: _________)
☐ I have never smoked

Neurological Disorders: epilepsy, seizures, black-outs, stroke, TIA, migraine headaches, vertigo, peripheral nerve-disorder (e.g., peripheral neuropathy, carpal tunnel syndrome), Parkinson's disease, Alzheimer's disease, muscular dystrophy, chronic pain, other neurological disorder (please specify)

Details: ____

Rheumatological and Soft Tissue Disorders: arthritis (e.g., osteo, rheumatoid), joint-pain, muscle pain, fibromyalgia, polymyalgia rheumatica, other disorder (please specify)

Details: ____

Psychological and Emotional Disorders: depression, anxiety, post-traumatic stress disorder (PTSD), bi-polar disorder, schizophrenia, other (please specify)

Details: ____

Endocrine, Renal and Blood Disorders: diabetes, hyperthyroidism (over-active thyroid gland), hypothyroidism (underactive thyroid gland), hepatitis A, hepatitis B, hepatitis C; contact with HIV / AIDS, anaemia, excessive bleeding, kidney disease, kidney stones, bladder problems, other (please specify)

Details: ____

Digestive Disorders: reflux (e.g., GORD), stomach ulcer, duodenal ulcer, bowel disorder (e.g., IBS), other (please specify)

Details: ____

Other Medical Conditions: (please specify and provide details)

____

____

____

____

Do you take any **non-prescribed** or **recreational drugs**?____

Do you have any **allergies**? ____

Have you had any serious **accidents** or **past hospital admissions?** (indicate approximate dates and details)

____

Do you have any **diseases** or **conditions** that **run in your family**? ______________________________________

____

Please note any **other information** you feel is relevant, including notes on any **nasal fractures, septal deviation, nasal** or **sinus problems**: ____

____

____

Please list all **current medications**, including any nasal sprays or medications for nasal allergies:

Medication Name	*Reason for Medication*	*Dosage*

If there is not enough room on this page to list your medications, please attach a separate sheet.

EPWORTH SLEEPINESS SCALE

In the following situations, please choose how likely you are to doze off / fall asleep by **circling** the appropriate number.

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

1. Sitting and reading	**0**	**1**	**2**	**3**
2. Watching TV	**0**	**1**	**2**	**3**
3. Sitting quiet in a public place (e.g., theatre or meeting)	**0**	**1**	**2**	**3**
4. As a passenger in a car for an hour without a break	**0**	**1**	**2**	**3**
5. Lying down to rest in the afternoon when circumstances permit	**0**	**1**	**2**	**3**
6. Sitting and talking to someone	**0**	**1**	**2**	**3**
7. Sitting quietly after lunch without alcohol	**0**	**1**	**2**	**3**
8. In a car, while stopped for a few minutes in the traffic	**0**	**1**	**2**	**3**

TOTAL: ___________________ out of 24

Who **recommended** that you have a sleep study? (please circle)

☐ Partner ☐ GP ☐ Specialist ☐Friend ☐ Family Member ☐ Self

☐ Other: ____

Additional Details: *Staff Use Only*

____

____

____

____

____

____

____