Snoring
Narcolepsy
Obstructive sleep apnea
Restless legs
Excessive daytime sleepiness

SNORE Australia

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CPAP REASSESSMENT – 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): _____

Phone (Home): _____ **Phone (Work):** _____ **Phone (Mobile):** _____

Occupation: _____

Email Address: _____

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:** _____

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

I hereby consent to: a polysomnographic sleep study and video recording of myself during the study, my medical details and sleep report(s) being released to the referring medical practitioner(s) and to any other medial 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:** _____

I consent / do not consent to my contact details and CPAP script being released by SNORE Australia Pty Ltd to **Air Liquide *Healthcare* so that they can contact me in order to offer suitable arrangements.**

Signed: _____ **Date:** _____

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

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: _____

Sleeping Position

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

Do you have a **problem sleeping on your back (supine)**? ☐ Yes ☐ No

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 / Peripheral Nerves

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? ☐ Yes ☐ No

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)? _____

Any additional comments: _____

Smoking and Alcohol:

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

On how many **evenings per week** do you **drink alcohol**? ☐ __ per week ☐ Never ☐ Special occasions only

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 Weight

What is your current **body weight**? _____kg

Amount of **weight gain** in past 12 months: _____kg or Amount of **weight loss** past 12 months: _____kg

CPAP History

Are you **currently using** CPAP therapy? ☐ Yes ☐ No

How long have you been using CPAP therapy? _____

What is the **pressure setting** on the CPAP machine you are currently using? _____ cmH_2O

How many **nights per week** do you use CPAP (on average)? _____

How many **hours of sleep** per night do you use CPAP for? _____

Are you using CPAP for the **entire night**? ☐ Yes ☐ No

Do you use a **chin strap**? ☐ Yes ☐ No

Do you use an **air humidifier** with your CPAP unit? ☐ Yes ☐ No

Do you use a **heated CPAP tube**? ☐ Yes ☐ No

What type of **CPAP mask** do you use?

Brand: ☐ Fisher & Paykel Model: _____
☐ ResMed _____
☐ Respironics _____
☐ Other (please specify): _____ _____

What type of **CPAP machine** do you use?

Brand: ☐ Fisher & Paykel Model: _____
☐ ResMed _____
☐ Respironics _____
☐ Other (please specify): _____ _____

How has your **daytime tiredness** changed since commencing CPAP treatment?

☐ Improved significantly ☐ Improved slightly ☐ Has not changed ☐ Worsened slightly ☐ Worsened significantly

How has the **quality of your life** changed since commencing CPAP treatment?

☐ Improved significantly ☐ Improved slightly ☐ Has not changed ☐ Worsened slightly ☐ Worsened significantly

CPAP Problems

Do you dislike CPAP therapy?	0	1	2	3
Do you get a rash or ulcers on your face due to irritation from your CPAP mask?	0	1	2	3
Do you experience difficulty breathing through your nose when using CPAP?	0	1	2	3
Do you have a sensation that your CPAP pressure is too high?	0	1	2	3
Do you unknowingly take your CPAP mask off during sleep?	0	1	2	3
Do you experience air escaping from your CPAP mask?	0	1	2	3
Does your mouth fall open (or does air escape from your mouth) during sleep?	0	1	2	3
Do you have troublesome dryness of your nasal passages and/or airways when using CPAP?	0	1	2	3

Do you have any other problems with CPAP not listed above? (please give details): _____

_____

_____

If you have **ceased using CPAP**, please indicate why:

☐ Local rash or ulceration on face due to irritation from CPAP mask
☐ Dislike of CPAP therapy
☐ Difficulty breathing through nose when using CPAP
☐ Sensation of air-pressure through the mask being too high
☐ Unknowingly taking CPAP mask off during sleep
☐ Air escaping from the mask or through your mouth when sleeping
☐ No continuing snoring or sleep apnoea when CPAP not used
☐ Sleep quality is worse with CPAP than without CPAP
☐ Persistence of excessive day-time sleepiness
☐ Using oral appliance (dental splint) instead with success
☐ CPAP ceased on doctor's instructions – please name the doctor: _____
☐ Other medical reasons (please comment): _____

_____

_____

Does your work involve **driving** (private or commercial)? ☐ Yes ☐ No

Please indicate if you received any **financial assistance** in obtaining your CPAP machine or paid personally:

☐ DVA ☐ Queensland Health CPAP Scheme
☐ Private Health Fund ☐ Program of Appliances for Disabled People (PADP) in NSW
☐ Privately funded – new machine ☐ Privately funded – second-hand machine
☐ Other (please comment): _____

Have you ever had a sleep-study at another sleep clinic? (if yes, please indicate which clinic and when): _____

_____

Have you ever attempted treatment with an **oral appliance** (dental splint)?

☐ No
☐ Yes → ☐ Please specify type: _____ Cost: $_____
☐ Did you receive any financial assistance? (see above question) _____

Please indicate if you are using any of the following **nasal sprays** at night:

☐ *Rhinocort* ☐ *Nasonex* ☐ *Beconase* ☐ Other (please specify): _____

Please list all **current medications**:

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 or 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

Please note any **other information** you feel is relevant: _____

_____

_____