

Snoring
Narcolepsy
Obstructive sleep apnea
Restless legs
Excessive daytime sleepiness



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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 Licence 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.

Patient Signature: _____ Parent/Guardian Signature: _____ Date: _____

Witness Name: _____ Witness Signature: _____

Witness Address: _____

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.

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

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 CO₂), 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:

<i>Medication Name</i>	<i>Reason for Medication</i>	<i>Dosage</i>

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**

How did you hear about SNORE Australia (please select all that apply)?

GP Specialist Friend Family member TV Radio Newspaper

Event (e.g., health expo) Letterbox drop Signage on a SNORE Australia clinic

Comments:

Additional Details: *Staff Use Only*

