Sleep Clinic

# PATIENT HISTORY

## PATIENT DETAILS

Title Mr / Mrs / Ms / Miss (Please circle as appropriate)

Given Name

Family Name

Preferred Name

## CONTACT DETAILS

Street Address

City / Suburb

State

Postcode

Mobile Phone (Select your preferred contact number)

Home Phone

Work Phone

Email Address

Date of Birth

Age

Height (cm)

Weight (Kg)

Occupation

Marital / Partner Status

Emergency Contact Name (First and Last Names)

Emergency Contact's Phone Number

Name of Private Health Fund

2 Digit Number Next to Name

## HOW DID YOU FIND OUT ABOUT OUR CLINIC?

| | | | |
|---|---|---|---|
| Google Search | ☐ | Family / Friends | ☐ |
| Facebook | ☐ | Walk In | ☐ |
| Doctor Referral | ☐ | | |
| Other | ☐ | | |

## CHIEF CONCERNS

| | | | |
|---|---|---|---|
| Snoring | ☐ | Sleep Apnoea | ☐ |
| Interrupted Sleep | ☐ | Tiredness | ☐ |
| Difficulty Concentrating | ☐ | Drowsy When Driving | ☐ |
| Other | ☐ | | |

What effects are these concerns having on your life?

Have you seen any health professionals for this problem? Yes ☐ No ☐

Who?

Have you had a diagnosis of Sleep Apnoea? Yes ☐ No ☐

If yes, where did you have sleep study? Year

Have you had a previous treatment for Sleep Apnoea? Yes ☐ No ☐

Please describe your treatment…

Continued Overleaf…

Sleep Clinic

# PATIENT HISTORY

## CAFFEINE

How many caffeinated beverages do you consume each day? (Cola / Coffee / Tea)

## ALCOHOL

How many alcoholic beverages do you consume each day?

## SMOKER

Have you ever been a smoker? Yes ☐ No ☐

How many each day?

When did you quit?

## SYMPTOMS (Please answer all the questions)

| | Yes | No |
|---|---|---|
| Do you feel unwell or not refreshed in the morning? | ☐ | ☐ |
| Has anyone heard you stop breathing or do you gasp or choke during sleep? | ☐ | ☐ |
| Are you sleepy during the day? | ☐ | ☐ |
| Do you experience sleepiness during driving? | ☐ | ☐ |
| Do you have memory or concentration problems? | ☐ | ☐ |
| Do you suffer from headaches? | ☐ | ☐ |
| Do you experience dry mouth? | ☐ | ☐ |
| Do you have restless legs in sleep? | ☐ | ☐ |

## SLEEPING PATTERN (Please answer all questions)

How long do you take to fall asleep?

The main reason for waking up?

What time do you wake in the morning?

How often do you awaken in the night?

Average total hours sleep per night?

What time do you go to bed at night?

## MEDICAL HISTORY (Please answer all the questions)

| Have you ever had any of the following? | Yes | No |
|---|---|---|
| High Blood Pressure / Heart Ailment | ☐ | ☐ |
| Asthma / Chest / Breathing Problems | ☐ | ☐ |
| Hay Fever / Allergies | ☐ | ☐ |
| Excessive Bleeding / Blood Disorder | ☐ | ☐ |
| Under treatment for serious illness | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Reflux | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Female Patients - Are you pregnant? | ☐ | ☐ |

Exercise Normal ☐ Restricted ☐

Any family history of serious health or sleep disorders?

Continued Overleaf…

Sleep Clinic

# PATIENT HISTORY

Name of your GP

Suburb

Are you under any medication? (Please list below)

## DENTAL HISTORY

Name of your Dentist

| | | |
|---|---|---|
| Have you ever had orthodontic treatment / braces? | Yes ☐ | No ☐ |
| Are you aware of clenching or grinding your teeth? | Yes ☐ | No ☐ |
| Do you ever have problems with chewing or jaw movements? | Yes ☐ | No ☐ |

## EPWORTH SLEEPINESS SCALE

On a scale of 0-3, how likely are you to doze off or fall asleep during the day in the following situations?

| **Situation** | Would never doze (0) | Slight chance of dozing (1) | Moderate chance of dozing (2) | High chance of dozing (3) |
|---|---|---|---|---|
| Sitting and reading | | | | |
| Watching television | | | | |
| Sitting inactive in a public place (Eg: cinema, meeting) | | | | |
| As a passenger in a car for an hour without break | | | | |
| Lying down to rest in the afternoon when able | | | | |
| Sitting and talking to someone | | | | |
| Sitting quietly after lunch without alcohol | | | | |
| Driving a car, while stopped for a few minutes in traffic | | | | |
| **TOTAL SCORE** | | | | |

## EPWORTH SCORING

<8 Indicates normal sleep function

8-10 Indicates mild sleepiness

11-15 Indicates moderate sleepiness

16-20 Indicates severe sleepiness

21-24 Indicates excessive sleepiness

Patient Signature

Print Name

Date

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