PATIENT HISTORY

bendigosleeplab
sleep & snoring solutions

Date: _____ **Please complete pages 1, 2, 3 and 4 and return 48 hours BEFORE your consultation.*

Name: _____ Date of Birth: _____ Age: _____

Occupation (current/previous): _____ Marital Status: _____ Children: _____

What is your home address? _____

Where do you live? (Home/Other): _____ Medicare number: _____

Hobbies: _____

What is your local doctor's name and address? _____

Are there any other practitioners involved with your care that you would like to be sent a copy of all correspondence: _____

_____

Q1. Do you smoke? YES / NO

Q2. Have you ever smoked? YES / NO

a) If Yes, maximum quantity smoked per day: _____

b) Year started smoking: _____

c) Year stopped smoking: _____

Q3. Passive smoke exposure LIGHT/ HEAVY

Q4. Alcohol Consumption (average per day - standard drinks):

_____

Q5. Recent blood pressure: _____

Q6. Height: _____ **Q7. Weight:** _____

Q8. Neck circumference: _____

Q9. a) Current Medications (for ALL reasons; please include doses and when started): *None*

1. *Medication and dose:* _____

   Reason: _____ *Year started:* _____

2. *Medication and dose:* _____

   Reason: _____ *Year started:* _____

3. *Medication and dose:* _____

   Reason: _____ *Year started:* _____

4. *Medication and dose:* _____

   Reason: _____ *Year started:* _____

5. *Medication and dose:* _____

   Reason: _____ *Year started:* _____

b) List any illnesses or operations you have had: *None*

1. *Illness:* _____ *Year:* _____
2. *Illness:* _____ *Year:* _____
3. *Illness:* _____ *Year:* _____
4. *Illness:* _____ *Year:* _____
5. *Illness:* _____ *Year:* _____
6. *Illness:* _____ *Year:* _____

Q10. Please list any drug allergies / reactions to anaesthetics that you have had: *None*

1 *Drug:* _____ *Type of reaction:* _____

_____

2. *Drug:* _____ *Type of reaction:* _____

_____

Q11. Have you received the following vaccinations (recent or in past)? If so, when?

Flu Vaccine: _____ Pneumovax: _____ BCG Vaccine (for Tuberculosis): _____

Q12. Has there been any past exposure to:

TB (Tuberculosis) / Asbestos: _____ Other noxious fumes and dusts (for prolonged periods): _____

Q13. Is there any major health related illness in your family? (Heart, cancer, Sleep Apnoea or heavy snoring, Diabetes) *None*

_____

_____

Q14. Are you exposed to pets or birds? If so, describe the exposure

_____

_____

Q15. Have you traveled overseas recently? If yes, please describe

_____

_____

Q16. When did you last have:

Chest X-Ray _____ Blood tests: _____

Q17. How far can you walk at a steady pace?

_____ or Unlimited ☐

Q18. **Please fill in the following sleep related questions**

Usual time of going to sleep: _____

Usual time of waking up: _____

How long does it take to fall asleep: _____

Do you awaken frequently at night? (toilet, etc) ○ YES/ ○ NO

Is your sleep refreshing? ○ YES/ ○ NO

Do you wake with a dry throat? ○ YES/ ○ NO

Are your legs restless at night? ○ YES/ ○ NO

Do you have caffeine at night? ○ YES/ ○ NO

Do you snore heavily? ○ YES/ ○ NO

a) If so, is it worse after alcohol ○ YES/ ○ NO

b) If so, is it worse on your back ○ YES/ ○ NO

Have you been observed to stop breathing? ○ YES/ ○ NO

Do you feel a choking sensation when sleeping? ○ YES/ ○ NO

Do you wake up with headaches? ○ YES/ ○ NO

Do you feel sleepy driving? ○ YES/ ○ NO

Have you had problems with memory or concentration? ○ YES/ ○ NO

Q19. **OSA 50**

OSA 50		If yes, circle SCORE
Obesity	Waist circumference* Male > 102cm Female > 88cm	☐ 3
Snoring	Has your **snoring** ever bothered people?	☐ 3
Apnoeas	Has anyone noticed that you **stop breathing during your sleep**?	☐ 2
50	Are you **aged 50** years or over?	☐ 2
	Total	

**Waist measurements need to be done at the level of the umbilicus (belly button).*

Q20. **Epworth Sleepiness Scale (ESS)**

How likely are you to doze off?	Never (0)	Slight (1)	Mod (2)	High (3)
Sitting and Reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place	☐	☐	☐	☐
Being inactive in a car as a passenger	☐	☐	☐	☐
Lying down to rest in the afternoon	☐	☐	☐	☐
Sitting and chatting to someone	☐	☐	☐	☐
Sitting quietly after lunch	☐	☐	☐	☐
In a car while stopped in traffic	☐	☐	☐	☐

Score: / 24

Q21. **STOP-BANG Questionnaire**

Please answer YES or NO to below questions	Yes	No
Do you snore loudly?	○	○
Do you often feel tired, fatigued, or sleepy during the daytime?	○	○
Has anyone observed you stop breathing during your sleep?	○	○
Do you have or are you being treated for high blood pressure?	○	○
Are you obese / very overweight – BMI more than 35 kg/m2?	○	○
Age over 50 years old?	○	○
Neck Circumference (collar size > 43cm male, 41 cm female)	○	○
Are you male?	○	○

Score: /8

Print form

I am aware all notes and letters will be stored securely and with confidentiality ○ YES/ ○ NO

I am aware fees are dependent on the consultation ○ YES/ ○ NO

My bank details are lodged with Medicare ○ YES/ ○ NO

If not, bank account name: _____ BSB: _____ Account number: _____