Patient Questionnaire

Name _____ Date of Birth:_____

Phone (home)_____(work)_____(Mobile)_____

Your Doctor's name:_____

Your Doctor's Phone if known:_____

Please tick yes or no. **(You may need to ask your bed partner for some of these answers).**

***Obstructive sleep Apnoea**

	Yes	No
1. Do you snore or have you been told you snore?		
2. Do you snore only when you are lying on your back?		
3. Do you snore loudly?		
4. Do you snore every night?		
5. Has your partner had to move to another room during the night?		
6. Have you had or been treated for high blood pressure?		
7. Do you doze off unintentionally during the day?		
8. Do you often wake feeling tired?		
9. Do you often wake in the morning with a headache?		
10. Do you have problems concentrating for long periods of time?		
11. Do you feel pain in your jaw joints (area of the ear)?		
12. Do you grind or clench your teeth in your sleep?		
13. Have you ever been diagnosed, or do you suspect you have OSA?*		
14. Have you ever been seen by a specialist for snoring or OSA?*		
15. Do you get night time or day time reflux?		
16. Have you ever had a sleep study?*		
17. Have you ever been treated for snoring, OSA or a sleep disorder?* *If yes, where and when?		

Family History

Do any family members snore, have OSA or sleep disorder, heart disease/blood pressure/diabetes?
Yes No

If Yes, who?_____

Epworth Sleepiness Scale

How likely are you to fall asleep in the following situations?

0= would never doze

1= slight chance of dozing

2=moderate chance of dozing

3= high chance of dozing

Activity	**SCORE**
Sitting and reading……	_____
Watching television……	_____
Sitting, inactive in a public place (theatre, meeting)…….	_____
As a passenger in a car for an hour with no break……	_____
Lying down to rest in the afternoon, if circumstances permit……	_____
Sitting and talking to someone……	_____
Sitting quietly after lunch with alcohol…….	_____
In a car while stopped for a few minutes in traffic……	_____
TOTAL SCORE	**_____**

A score of 10 or above indicates you may be having a problem with daytime sleepiness.

However, below 10 does not necessarily mean you do not have a problem.

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Personal Information

Weight:

Height:

Neck circumference:

Male: greater than 43cm Female: greater than 41cm

Alcohol consumption (units per week)_____

Smoking consumption (cigarettes/cigars per week)_____

OSA Symptoms (if patient answers yes to one or more, consider referral to a GP)

	YES	NO
Choking or gasping during sleep		
Tiredness on waking		
Sore, dry throat on waking		
Morning headache, excessive daytime sleepiness		
Decreased sex drive or impotence		
Gastro-oesphageal reflux		
Nocturia		
Personality changes, which may include irritability		
Decreased job performance		
Anxiety or depression		
Poor concentration / memory