THE WESLEY HOSPITAL - BRISBANE
THE JOHN FLYNN HOSPITAL - GOLD COAST
NAMBOUR SELANGOR HOSPITAL - NAMBOUR

Patient Questionnaire

THORACIC & SLEEP GROUP QUEENSLAND

General hospital staff are not responsible for the receipt of this questionnaire. Please hand to the *sleep centre staff* on the night of your study.

Office Use Only **Study Date:**_____ **Clinic:** W JF SN **Study Type:** DSS CPAP Return CPAP BPAP MAS O_2 +MSLT

Surname:_____ **First name:**_____ **Occupation:**_____

D.O.B:_____ **M / F** **Preferred Contact Number:**_____ **Usual GP:**_____

Emergency Next of Kin:_____ **Emergency Contact Number:**_____ / _____
Home Number Mobile Number

Sleep History

1. What time do you usually go to bed?_____**am / pm** **and what time do you rise?**_____**am / pm**

2. How much sleep per night do you think you get?_____**Hrs** **Is this enough sleep?** ❑ **Yes** ❑ **No**

3. Do you usually nap or doze during the day? ❑ **Yes** ❑ **No** **If 'Yes', from what time?**_____ **and for how long?**_____

4. Do you have trouble falling asleep at night? ❑ **Yes** ❑ **No** **or staying asleep at night?** ❑ **Yes** ❑ **No**

If 'Yes' is there any reason for this that you are aware of?_____

5. Do you, or has anyone witnessed you snoring loudly? ❑ **Yes** ❑ **No** **or stop breathing at night?** ❑ **Yes** ❑ **No**

Medical History

1. Do you have or have you had or been treated for any of the following medical conditions (circle if 'yes')?

Cardiac Pacemaker / High blood pressure / Heart attack (MI) / Transient Ischemic Attack / Asthma / COPD
Pulmonary Oedema / Diabetes / Epilepsy/Seizures / Kidney Failure/Disease / Depression / Anxiety / Schizophrenia

2. Do you normally suffer from nasal congestion? ❑ **Yes** ❑ **No** **If 'Yes', does this impact your breathing at night?** ❑ **Yes** ❑ **No**

3. Do you have any known allergies or have a history of high skin sensitivity ❑ **Yes** ❑ **No** **If 'Yes', please list**_____

_____

4. Are you currently cytotoxic or undergoing chemotherapy? ❑ **Yes** ❑ **No**

5. Please list all medications (prescribed and non-prescribed) you are taking at present and how often you take them (attach list if needed)

Name:_____ Dosage:_____ Name:_____ Dosage:_____
Name:_____ Dosage:_____ Name:_____ Dosage:_____
Name:_____ Dosage:_____ Name:_____ Dosage:_____
Name:_____ Dosage:_____ Name:_____ Dosage:_____

Lifestyle

1. Do you smoke cigarettes? ❑ **Yes** ❑ **No** ***or*** **Have you previously smoked?** ❑ **Yes** ❑ **No, for** _____ **years. Quit**_____**years ago**

If 'Yes', how many cigarettes do/did you smoke?_____ **per** ❑ **Day** ❑ **Week**

2. How many standard alcoholic drinks do you consume on average? _____**per weekday and** _____**on weekends**

3. Do you take any recreational drugs? ❑ **Yes** ❑ **No** **If 'Yes', please list**_____

4. How would rate your level of daily physical activity? ❑ **Little to none** ❑ **Low Intensity** ❑ **Moderate Intensity** ❑ **High Intensity**

5. Are you a shift worker? ❑ **Yes** ❑ **No** **If 'Yes', what shift do you work?**_____

Epworth Sleepiness Scale (ESS) - How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. If you haven't done some of these activities recently, try to work out how they would have affected you. *Use the following scale to choose the most appropriate number for each situation. It is important to circle a number for EVERY situation.*

0 = You would never doze off **1 = There is a slight chance of dozing** **2 = There is a moderate chance of dozing** **3 = There is a high chance of dozing**

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (eg theatre or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped in traffic for a few minutes	0	1	2	3

Total ESS:_____**/24**

Your sleep study preparation checklist:

- This form (and any other paperwork, just in case)
- Pajamas
  (tops and bottoms preferred over nightgowns)
- Toiletries
- Medications
- Make sure to have dinner (or bring it with you)
- A nightcap (this is accepted in the sleep lab)

THORACIC & SLEEP GROUP QUEENSLAND

Consent Form

Dear Sir/Madam,

The sleep centre you will be attending (of The Thoracic and Sleep Group Queensland) provides Level 1 (the most extensive and sensitive) Sleep Study services to its patients. As part of this service we require written consent from yourself or from a legal guardian on behalf of yourself, to permit a Level 1 Sleep Study be performed including a video recording of yourself exclusively during your sleep study.

I _____FULL NAME_____**, born** _____D.O.B_____ **acknowledge that I have read and understand the supplied documentation provided to me by the Medical Directors of the Thoracic and Sleep Group Queensland, that explains the procedures and risks involved in having a sleep study performed and have had the opportunity to ask questions about the procedure.**

I understand that by signing this document I am not obliged to undertake this procedure if for any reason I change my mind in the future. I understand that the company (The Thoracic & Sleep Group Queensland) may ONLY use the results and video recording of myself to accurately diagnose and monitor any such sleep disorder that I am suspected of having.

I acknowledge that I am liable for any fee that is not covered by my private health fund and failure to make payments may result in the transfer of the account to a debt collection agency and also be liable for any fees incurred.

The Thoracic & Sleep Group Queensland is also involved in the training and education of medical students. As part of this affiliation, our company offers teaching and educational support to students in the field of Sleep Medicine. By signing below, you provide permission to The Thoracic and Sleep Group Qld to use your sleep study results in the facilitation of teaching and educational support to our medical students. Please be advised that in any event, your personal information will remain anonymous (including your name, date of birth, and contact details). Your sleep study results will remain solely with The Thoracic and Sleep Group Queensland and your referring doctor/general practitioner.

1) I _____FULL NAME_____ **hereby consent to the utilization of my sleep study results in facilitating teaching and educational support to medical students in the field of Sleep Medicine. I understand that The Thoracic and Sleep Group Queensland will ensure that any personal information will remain anonymous for the purposes of teaching and educational support.**

2) I _____FULL NAME_____ **<u>DO NOT</u> consent to the utilization of my sleep study results in facilitating teaching and educational support to medical students. I understand that by withholding my consent, the results of my sleep study will ONLY be viewed by The Thoracic and Sleep Group Queensland's faculty.**

(a) Patient's Signature:_____ **Date:**_____

(b) Legal Guardian's Signature:_____ **on behalf of** _____PATIENT'S NAME_____

Ht (cm): **Wt (kg):**

Office Use Only

<u>Evening Questions</u> *(These questions are related to the day of the sleep study)* **pm BP:**_____

1. Did you nap today?_____ If so, at what time?_____ and for how long?_____

2. Did you consume alcohol today?_____ If so, how many standard drinks?_____ and at what time?_____

3. Did you have caffeine this evening?_____ If so, how much?_____ and at what time?_____

4. Are you taking or have taken a sleeping pill/sedative tonight?_____ If so, what brand & dose?_____

<u>Morning Questions</u> *(These questions are related to the sleep quality on the night of the study)* **am BP:**_____

1. How long did it take you to go to sleep (your guess)?_____ Is this shorter, the same or longer than usual?_____

2. How much sleep did you get in total (your guess)_____ Is this more, the same, less or much less than usual?_____

3. Did you wake up less, the same or more amount of times than usual?_____

4. What woke you this morning? *Spontaneous / Technician / Uncomfortable / Noise / Light*

5. Do you feel this morning? *Tired and sleepy / Awake but not alert / Well rested / Wide awake and alert*

6. How do you rate your sleep overall compared to usual? *Much worse / Worse / The same / Better / Much better*

7. Did you have overwhelming problems with the CPAP system overnight (only answer if you were trialing CPAP)?_____