Print Reset Form

Queensland Government

**Royal Brisbane and Women's Hospital**

# SLEEP PATIENT QUESTIONNAIRE

(Affix patient identification label here)

URN:.....

Family Name:.....

Given Names:.....

Address:.....

Date of Birth: ..... ..... ..... Sex: ☐ M ☐ F ☐ I

**Note:** This form is an interactive form that can be completed electronically or in hardcopy. To complete electronically, click at the beginning of the dotted line/s.

Contact phone number:..... Contact email:.....

Emergency contact:..... Relationship:..... Emergency contact number:.....

Referring doctor:..... Referring doctor's address:.....

GP/Family doctor:..... GP/Family doctor's address:.....

Medicare card number:..... Medicare Reference Number:..... Expiry:.....

Pension card number (if applicable):..... Expiry:.....

Healthcare card number (if applicable):..... Expiry:.....

Have you had a previous sleep study? ☐ Yes ☐ No
If *Yes*, where and when (specify month and year)?

Have you used a CPAP or Bilevel machine before? ☐ Yes ☐ No
If Yes, for how many years?..... At what pressure?.....

## PATIENT HEALTH HISTORY

**Have you suffered from any of the following symptoms or medical conditions?**

| | | | | | |
|---|---|---|---|---|---|
| Heart failure | ☐ Yes | ☐ No | Current smoker | ☐ Yes | ☐ No |
| Pacemaker / Defibrillator | ☐ Yes | ☐ No | If Yes, how many per day?..... How many years?..... | | |
| Chest pain / Angina | ☐ Yes | ☐ No | Ex-smoker | ☐ Yes | ☐ No |
| High blood pressure | ☐ Yes | ☐ No | If Yes, how many per day?..... How many years?..... | | |
| Other heart condition:..... | ☐ Yes | ☐ No | When did you quit?..... | | |
| Blood clot in legs or lungs | ☐ Yes | ☐ No | Morning headaches | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No | Broken nose | ☐ Yes | ☐ No |
| Alcohol related problems | ☐ Yes | ☐ No | Claustrophobia | ☐ Yes | ☐ No |
| Drug related problems | ☐ Yes | ☐ No | Incontinence | ☐ Yes | ☐ No |
| Deafness | ☐ Yes | ☐ No | Chronic Pain | ☐ Yes | ☐ No |
| Blindness | ☐ Yes | ☐ No | Heartburn / Acid reflux | ☐ Yes | ☐ No |
| Insomnia | ☐ Yes | ☐ No | Epilepsy / Fits | ☐ Yes | ☐ No |
| Anxiety / nerves | ☐ Yes | ☐ No | Cataplexy | ☐ Yes | ☐ No |
| Depression | ☐ Yes | ☐ No | Narcolepsy | ☐ Yes | ☐ No |
| Stroke | ☐ Yes | ☐ No | Tonsillitis / recurrent sore throat | ☐ Yes | ☐ No |
| Mental illness:..... | ☐ Yes | ☐ No | Hay fever / sinusitis | ☐ Yes | ☐ No |
| Neuromuscular disorder:..... | ☐ Yes | ☐ No | Allergies (including medications) | ☐ Yes | ☐ No |
| Shortness of breath | ☐ Yes | ☐ No | *Specify:*..... | | |
| Emphysema / COPD | ☐ Yes | ☐ No | | | |
| Asthma | ☐ Yes | ☐ No | | | |
| Other lung problems:..... | ☐ Yes | ☐ No | | | |

**Please list ALL past and present medical conditions not previously listed:**

| Present | Past |
|---|---|
| | |
| | |
| | |
| | |



SLEEP STUDY PATIENT QUESTIONNAIRE



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**Are you currently taking any prescription OR non-prescription medication? If *Yes*, please list:**

| Medication name | Reason | Dose | Year |
|---|---|---|---|
| | | | |
| | | | |
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**Please describe your sleep problem. What are your concerns with regards to your sleep or daytime functioning?**

## PATIENT SLEEP HISTORY

**Please answer the following questions about your sleep:**

Do you snore? ☐ Yes ☐ No

Have you noticed you stop breathing when you sleep? ☐ Yes ☐ No

Have you ever fallen asleep while driving? ☐ Yes ☐ No

Have you ever fallen asleep while operating machinery? ☐ Yes ☐ No

Do you hold a commercial driver's licence? (e.g. taxi, truck etc.) ☐ Yes ☐ No

Does pain disturb your sleep? ☐ Yes ☐ No

Do you experience unpleasant leg sensations at bedtime? ☐ Yes ☐ No

Have you ever had unusual movements or behaviours during sleep? ☐ Yes ☐ No

Describe:.....

If appropriate — age and gender, have you gone through menopause? ☐ Yes ☐ No

Do you wake unrefreshed? ☐ Yes ☐ No

Do you awaken with shortness of breath? ☐ Yes ☐ No

In the daytime are you chronically sleepy, fatigued or tired? ☐ Yes ☐ No

Do daytime worries keep you awake at night? ☐ Yes ☐ No

Do you grind your teeth during sleep? ☐ Yes ☐ No

Do you kick or jerk your arms or legs during sleep? ☐ Yes ☐ No

Do you go to the toilet frequently overnight? ☐ Yes ☐ No

If *Yes*, how many times on average per night?.....

Do you take sleeping tablets? ☐ Yes ☐ No

If *Yes*, how often?

☐ Nightly ☐ When necessary

Name of tablet:.....

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## ADDITIONAL QUESTIONS

How many cups or glasses would you consume per day? Tea: ..... Coffee: ..... Cola: ..... Alcohol: .....

What time do you drink your last tea / coffee or caffeine drink before going to bed? ..... .....

What time do you drink your last alcoholic drink before going to bed?

Do you have or ever had any infectious diseases?

☐ None ☐ Methicillin Resistant Staphylococcus Aureus (Golden Staph) ☐ Vancomycin Resistant Enterococci (VRE)

☐ Multi-resistant Acinetobacter Baumannii (MRAB) ☐ Other — specify: .....

What year were you infected? .....

What was the site of the infection? .....

Are you wheelchair bound? ☐ Yes ☐ No

Do you require an interpreter? ☐ Yes ☐ No

If *Yes*, what language? .....

Do you require a carer with you on the night of your sleep study? ☐ Yes ☐ No

Do you require a special diet? ☐ Yes ☐ No

If *Yes*, what type? .....

What is your approximate height? ..... cm

What is your approximate weight? ..... Kg

Are you interested in Sleep research and would you like to be contacted to find out more about sleep research projects being undertaken at RBWH? ☐ Yes ☐ No

What is your usual bedtime?

How long does it take you to fall asleep at bedtime? .....

What time do you usually get up in the morning? .....

How often do you wake between going to bed and getting up in the morning? .....

How long does it take you to return to sleep? .....

If you do wake during the night what is/are the usual causes? .....

Do you take naps? If so, how frequently (daily / weekly) and for how long? .....

If you (or your referring Doctor) did not complete the 3 questionnaires overleaf: (STOP-Bang, OSA50, Epworth Sleepiness Scale) on any paperwork when you were referred to us, please do so now. If you have already completed these questionnaires when you were referred to us, please skip these and move on to the last question before signing and dating this form. Thank you.



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## ADDITIONAL QUESTIONS continued…

### STOP-Bang[1]

| | |
|---|---|
| S – Do you SNORE loudly? (Louder than talking or to be heard through closed doors) | ☐ Yes |
| T – Do you often feel TIRED, fatigued or sleepy in the daytime? | ☐ Yes |
| O – Has anyone OBSERVED you stop breathing during your sleep? | ☐ Yes |
| P – Do you have or are you being treated for high blood pressure? | ☐ Yes |
| B – BODY Mass Index more than 35kg/m$^2$? | ☐ Yes |
| A – AGE over 50 years old | ☐ Yes |
| N – NECK circumference greater than 43cm males / 41cm females | ☐ Yes |
| G – Gender: MALE? | ☐ Yes |
| Each positive response to be given a score of 1 **TOTAL score:** | |

**OR**

### OSA50[2]

| | |
|---|---|
| O – Obesity<br>Is your waist circumference > 102cm (Male) or >88 cm (Female)? | ☐ No<br>☐ Yes – score 3 |
| S – Snoring<br>Has your snoring ever bothered other people? | ☐ No<br>☐ Yes – score 3 |
| A – Apnoea<br>Has anyone noticed that you stop breathing during your sleep? | ☐ No<br>☐ Yes – score 2 |
| 50 – Age<br>Are you aged 50 years or over? | ☐ No<br>☐ Yes – score 2 |
| ( ) = score **TOTAL score:** | |

**AND**

### Epworth Sleepiness Scale[3] Questionnaire

| **Scenario** | **Tick one score for each scenario** | | | |
|---|---|---|---|---|
| **Score** | 0 | 1 | 2 | 3 |
| Sitting and reading | ☐ | ☐ | ☐ | ☐ |
| Watching television | ☐ | ☐ | ☐ | ☐ |
| Sitting inactive in a public place (e.g. theatre or meeting) | ☐ | ☐ | ☐ | ☐ |
| A passenger in a car for an hour without a break | ☐ | ☐ | ☐ | ☐ |
| Lying down in the afternoon when circumstances permit | ☐ | ☐ | ☐ | ☐ |
| Sitting and talking to someone | ☐ | ☐ | ☐ | ☐ |
| Sitting quietly after lunch without alcohol | ☐ | ☐ | ☐ | ☐ |
| In a car, while stopped for a few minutes in traffic | ☐ | ☐ | ☐ | ☐ |
| **TOTAL score:** | | | | |

For the 8 scenarios described at left, ask the patient how likely they are to doze off or fall asleep in that situation as opposed to feeling just tired.

Use the following scoring scale:

0 = No chance of dozing

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

Then total the scores.

Do you have any cultural, religious or gender requirements we need to be aware of if/when you have your sleep study? If so, please specify:

.....

.....

.....

.....

.....

.....

Patient signature:..... Date of completion:..../..../.....

Thank you for completing this questionnaire. Please return it via email to: RBWH-Thoracic-Referrals@health.qld.gov.au, or fax to (07) 3646 5651 or, if you are here in person, please return it to the Administration Officer at Reception.

**Print**

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[1] Chung F et al., Anaesthesiology 2008 & Br J Anaesth 2012. Used under licence, University Health Network, Toronto, Canada.
[2] Chai-Coetzer CL et al., Thorax 2011
[3] Johns M Sleep 1991