SYDNEY SLEEP CENTRE

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Acquaintance Form

Please answer these questions as completely as possible. It will help us provide the best treatment for you. If you are away from our Centre, you may fill the in the form on screen or by printing it out. Please email the completed form to info@sleepcentres.com.au

How did you hear about us? (Please tick the appropriate box)

☐ Our website ☐ Word of mouth ☐ GP ☐ Specialist ☐ Other

Date today .....

Patient name:.....

Preferred name:.....

Date of birth: .....

☐ Male ☐ Female

☐ Married ☐ Single ☐ Child ☐ Other

Email:.....

Home phone:.....

Work phone:.....Mobile: .....

Address:.....

Referring doctor:.....

Preferred method of contact ☐ Phone ☐ Email ☐ SMS (text)

Medicare Card no: ☐☐☐☐ ☐☐☐☐☐ ☐ Ref no: ☐ Expiry:.....

Are you in a health fund: ☐ No ☐ Yes

If 'Yes', which one?.....

Do you have any of the following? Please tick

☐ Codeine allergy	☐ Asthma	☐ Healing complications	☐ Heart murmur
☐ Penicillin allergy	☐ Cancer	☐ Excessive bleeding	☐ Hepatitis: Type_____
☐ Sulphur allergy	☐ Diabetes	☐ Recurrent headaches	☐ High blood pressure
☐ Other allergy	☐ Dizziness	☐ Radiation treatment	☐ Kidney disease
☐ Anaemia	☐ Epilepsy	☐ Respiratory problems	☐ Liver disease
☐ Arthritis	☐ Fainting	☐ Tuberculosis	☐ Hay fever
☐ Artificial joints	☐ HIV	☐ Rheumatic fever	☐ Other

Please list all your medications

.....

.....

.....

What is your present concern?

.....

.....

.....

.....

.....

Personal Information

Weight: ..... Height: .....

Alcohol consumption (units per week) .....

Have you been a smoker before? ☐ Yes ☐ No. If 'Yes', for how long? .....

Current smoking (cigarettes per week) .....

OSA 50 Screening Questionnaire

If yes, SCORE

Obesity: Waist circumference*: males > 102 cm or females > 88 cm 3

Snoring: Has your snoring ever bothered other people? 3

Apneas: Has anyone noticed that you stop breathing during your sleep? 2

50: Are you aged 50 years or over? 2

TOTAL SCORE (out of 10): .....

* Waist circumference to be measured at the level of the umbilicus (belly button).

Your sleep

How many hours of sleep do you obtain each night? .....

How long does it take you to fall asleep in bed? .....

Do you have difficulty falling asleep again overnight after awakening? ☐ Yes ☐ No

Do you wake up refreshed the next day? ☐ Yes ☐ No

Do you feel tired during the day? ☐ Yes ☐ No

Have you ever had a sleep study? ☐ Yes ☐ No

If 'Yes', where, when, result? .....

.....

.....

Have you ever been seen by a specialist for snoring or sleep apnea? ☐ Yes ☐ No

Have you ever been treated for snoring or a sleep disorder? ☐ Yes ☐ No

Do any family members have sleep apnea or a sleep disorder? ☐ Yes ☐ No

If yes, who? .....

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

0 = would never fall asleep
1 = slight chance of falling asleep
2 = moderate chance of falling asleep
3 = high chance of falling asleep

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	.....
Sitting and talking to someone	.....
Sitting quietly after lunch without alcohol	.....
In a car while stopped for a few minutes in traffic	.....

TOTAL SCORE: 0

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

(If the score is not created automatically, please add the numbers manually.)

What now?

If you have completed the form on a computer, save it before emailing it to us. If you have filled it in on a phone or tablet, simply email it. If you have filled it in by hand, you can fax it to us or scan and email it. Or just pop it in the mail.