Sydney Sleep Centre Pty Ltd
ACN: 600 689 254

T. (02) 9252 6144
Suite 202, Level 2, 139 Macquarie Street
Sydney NSW 2000

Acquaintance Form

Dear Patient, Welcome to our office!

Please answer these questions as completely as possible. It will assist us greatly to provide the best treatment for you.

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

	Our website		Word of mouth		Other
	GP introduced our services		Specialist ______________________		

Patient Name: ______________________ **Date:** ______________

Date of Birth: ______________ ☐ **Male** ☐ **Female** ☐ **Married** ☐ **Single** ☐ **Child** ☐ **Other**

Preferred Name: ______________________ **Email:** ______________________

Phone (Home): ______________ **(Work):** ______________ **(Mobile):** ______________

Address: ____

Referring Doctor: ______________________

Preferred Method of Contact: ☐ **Phone** ☐ **Email** ☐ **SMS**

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 – how long? ____________

Current smoking (cigarettes per week) ____________

OSA 50 Screening Questionaire

		If yes, SCORE
Obesity:	Waist circumference* - Males >102cm or Females >88cm	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:	.... / 10 points

* Waist circumference to be measured at the level of the umbilicus.

How many hours 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? If Yes, where, when, result?	☐ Yes	☐ No
Have you ever been seen by a specialist for snoring or Sleep Apnoea?	☐ Yes	☐ No
Have you ever been treated for snoring or a sleep disorder?	☐ Yes	☐ No

Family History

Do any family members snore, have Sleep Apnoea 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:

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