

Suite 203, Level 2, 12 O'Connell Street Sydney, 2000 Phone 02 9252 6144

# 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

Todays Date:	/	/				
How did you hear	r about	us? (Please	tick the	appropriat	e box)	
Our website	ΠV	Vord of mouth		SP 🗆 S	pecialist	Other
Patient details						
First name:			Last	name:		
Date of Birth:	/	/	Male	Female	Other	
Address:						
Referring doctor:						
Mobile:		Email:				
Preferred method of c	ontact:	Phone	Email	SMS		
Medicare Card no:				Ref:	Expiry date:	
Are you in a health fund: No Yes If 'Yes', which one? Please list any diagnosed medical conditions.						

# Please list all your medications.

#### What is your present concern?

# **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 refereshed 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
Do any family members have sleep apnea or a sleep disorder?	Yes	No

### **Personal Information**

Weight:	Height:	Alco	ohol Co	nsumption (units per week)
Have you been	a smoker before?	Yes	No.	If 'Yes', for how long?

# **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 sle	eep?2
50: Are you aged 50 years or over?	2
T	OTAL SCORE (out of 10):

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

# **EPWORTH SLEEPINESS SCALE**

How likely are you to fall asleep in the following situations? 0 = never, 1 = slight chance, 2 = moderate chance, 3 = high chance		
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.

#### PRACTICE POLICIES

There is a cancellation fee of 100% of the consultation fee if less than 24 hours notice is given.

On signing this consent form, I agree that my credit card will be charged for a cancellation as per above.

Card Number:	Expiry Date:
	1,2

Name:

. .

Date: / /

Signature: