

Patient Questionnaire



Patient Name: _____ Date of Birth: _____
Phone (home): _____ (work) _____ (mobile) _____
Your Doctor's (GP) name: _____
Your Doctor's (GP) address: _____ Phone: _____
Referring Specialist Physician's Name: _____ Phone: _____

Medical Conditions

Do you have any condition that your GP is aware of?

Respiratory	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cardiovascular	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Renal	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Digestive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neurological	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please tick yes or no. **(You may need to ask your bed partner for some of these answers).**

- | | | |
|---|------------------------------|-----------------------------|
| 1. Do you snore or have you been told you snore? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Do you snore only when you are lying on your back? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Do you snore loudly? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Do you snore every night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Have you been told you stop breathing or gasp during sleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Has your partner had to move to another room during the night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have you had or been treated for high blood pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Do you doze off unintentionally during the day? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Do you often wake feeling tired? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Do you often wake in the morning with a headache? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Do you have problems concentrating for long periods of time? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Do you feel pain in your jaw joints (area of the ear)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Do you grind or clench your teeth in your sleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Have you ever been diagnosed, or do you suspect you have OSA?* | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Have you ever been seen by a specialist for snoring or OSA?* | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Have you ever had a sleep study?* | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Have you ever been treated for snoring, OSA or a sleep disorder?* | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

* If yes, where and when? _____

Family History

Have any family members had heart disease/high blood pressure/diabetes? Yes No

Do any family members snore, have OSA or a sleep disorder? Yes No

Is yes, who? _____

Personal Information

Weight: _____

Height: _____

Neck circumference: _____

Male: greater than 43cm Female: greater than 41cm

Alcohol consumption (units per week) _____

Smoking consumption (cigarettes/cigars per week) _____