Patient Registration & Information Form:

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.

397 Crown Street Wollongong NSW 2500
ph: 02 4227 2516 | *fax*: 02 4227 2648
email: **sleep@thesleeplab.com.au**

Title:	☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other
Surname:	Middle Initial:
First Name:	Date of Birth: / /
Street Address:	
Postal Address: (If different to street address)	

Mobile Phone:	Home Phone: Work Phone:
Email:	
Occupation:	
Medicare No:	Ref: Expiry Date:
DVA Gold / White:	
Private Health Fund Y/N	Fund Name: Member No:
Pension / HCC Number:	
Next of Kin: (Name, Address and Telephone Number) Relationship to Patient:	
Emergency Contact: (If different to Next of Kin)	

Do you have any allergies or sensitive to drugs or dressings? ☐ Yes (please list below) ☐ No

....

....

Signature: .... Date: .... / .... / ....

I confirm there is no other information that I am aware of that would influence the medical treatment /advice to be provided.

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Patient Registration & Information Form:

Have you had a sleep study before?

☐ Yes ☐ No If so, where and when? ____________________

What time do you normally go to sleep? ____________________

Your sleep history: Do you have or have you had a history of...?

☐ Snoring
☐ Witnessed apnoea
☐ Wake unrefreshed
☐ Always feeling tired
☐ Experience daytime sleepiness
☐ Restless legs
☐ Morning headache
☐ Daytime naps
☐ Teeth grinding
☐ Other ____________________

Your health history: Do you have or have you had a history of...?

☐ Operations:

Details: ____________________ Date: ____________________

Details: ____________________ Date: ____________________

Details: ____________________ Date: ____________________

Asthma	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Chronic Illness	☐ Yes	☐ No
Other	☐ Yes	☐ No

Current medications (including over the counter medications, vitamins and minerals):

____

____

____

____

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Family history –have any members of your family been diagnosed with or suffered from:

☐ Diabetes ______________________________

☐ Asthma: ______________________________

☐ Heart Disease: ______________________________

☐ Mental illness: ______________________________

☐ Cancer: ______________________________

Social history:

☐ Tobacco:
- ☐ I have never smoked tobacco
- ☐ Ceased smoking: / /
- ☐Current Smoker
- Number of Cigarettes per week:

☐ Alcohol:
- ☐ I do not drink alcohol
- ☐ Days per week:
- ☐ Drinks per day:
- ☐ Drinks per week/month:
- How often would you drink more than 6 drinks per day?

☐ Recreational Drug use: ______________________________ (type and frequency)

Physical Measurements:

Height (cm) ______________________________

Weight (kg) ______________________________

Waist Measurement (cm) ______________________________

Is there any other information that you believe we should know that may affect / or have an influence on the medical treatment / advice you will be provided with?

If yes, please provide details below:

____

____

____

I give consent for my data to be used for research purposes. I understand that my data will be de-identified and remain confidential. ☐ Yes ☐ No

Signature: .... **Date:** .... / .... / ....

Thank you for your co-operation

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Epworth Sleepiness Scale[1]

Name:	______________________	Date:	______________________
D.O.B	______________________	Sex:	______________________

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you have not done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation.

0 = **no chance** of dozing

1 = **slight chance** of dozing

2 = **moderate chance** of dozing

3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	Chance of dozing (0-3)
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstance permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total:	**/24**

Interpretation of ESS Total Score

Score	Interpretation
0 – 10	Normal
11 – 24	Abnormal – Clinical review recommended

1 Introduced in 1991 by Dr Murray Johns of Epworth Hospital, Melbourne, Australia
(Copyright © M.W. Johns 1990-1997) Johns MW Sleep 1991; 14(6): 540-545.

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