Dr Bliegh MUPUNGA

MB CHB, MMED (UZ), MRCP (UK), FRACP, FCCP

Respiratory and Sleep Physician

Provider No: 282372 DT

North Coast Surgical Suite
Suite 14, Level 4
20 Dalley Street
East Lismore NSW 2480
P: 02 6621 8277
F: 02 6621 6669
E: reception@ncssuite.com.au

Confidential Patient Information

(Patient to fill out the following details)

Full Name: ……..

Date of Birth: ……

Address: ……

Suburb …… Post Code: ……..

Is this your postal address? Yes / No

If no, your postal address: ……

Medicare Number: …….. Reference No. ……

Expiry Date: ……

For administration use only:

Date of study:

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Epworth Sleepiness Score

(subjective measure of sleepiness)

Date: ……

Name: ……..

Date of Birth: …… Age: ……

Gender: M/F (circle)

How likely are you to 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 of each situation.

0 = would ***never*** doze
1 = ***slight*** chance of dozing
2 = ***moderate*** chance of dozing
3 = ***high*** chance of dozing

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

Guide to interpretation:
If your score is greater than 8 points, then you are sleepy. If your score is more than 10 points
you are very sleepy. If your score is more than 16 points you are dangerously sleepy, discuss this with your doctor.

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Confidential Patient Questionnaire

Name: ……

Date of Birth: ……

Gender: ……

Referring Doctor: ……

The following information is requested to assist us in giving you the best possible care. All of the information you provide will be treated as strictly confidential. Try as best as you can to answer all the questions. If you are certain that a question does not apply to you, leave it blank.

Section 1 (circle)

Do you ***snore*** loudly (louder than talking or loud enough to be heard through closed doors)?	Yes / No
Do you often feel ***tired***, fatigued, or sleepy during daytime?	Yes / No
Has anyone observed you ***stop*** breathing during your sleep?	Yes / No
Do you have or are you being treated for ***high blood*** **pressure**?	Yes / No

NB: What is your current height? ……. cm and weight? ……. kg

Please measure your neck circumference and write it in space provided …….. cm

Section 2

Listed below are hypothetical statements about night and daytime symptoms. Please circle an answer most true to your situation:

My **nose blocks** up when trying to sleep (allergies, infections)	Yes / No
I wake with a **dry mouth**	Yes / No
I wake in the morning with a **headache**	Yes / No
I have daytime naps (Average number per day = …….)	Yes / No
I suffer from impairment of **memory**	Yes / No
I find it difficult to **concentrate**	Yes / No
I experience **restless legs,** which stop me from falling asleep	Yes / No
I experience or I am told that I **sleep walk/talk**	Yes / No
My sleep is disturbed by pain in the neck/back/muscles/joints/legs/arms/chest?	Yes / No

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Section 3

This section asks a number of questions related to your typical sleep habits. **Please provide an answer on the dotted line.**

At what time do you usually go to bed?	…….	
Do you take something to help you get to sleep?		Yes / No
Please specify what you take.	…….	
Do you feel you typically get enough sleep during the night?		Yes / No
How many times do you estimate that you wake up during the night?	…….	
Do you work rotating shifts or unusual times?		Yes / No

Section 4

Do you **smoke** cigarettes? Yes / No

If you do not smoke now, have you smoked in the past? Yes / No

Do you drink **alcohol every day**? Yes / No

Do you have any of the following serious medical conditions:

- Severe COPD (with FEV1/FVC < 70% and FEV1 < 50% predicted) Yes / No
- Regular use of supplemental oxygen Yes / No
- Oxygen level ≤ 92% Yes / No
- Hypoventilation syndrome (e.g. CO2 ≥ 45mmHg) Yes / No
- Morbid obesity (BMI ≥ 45kg/m2) Yes / No
- Uncontrolled heart failure Yes / No
- Chronic opioid use Yes / No
- Neuromuscular / chest wall deformity Yes / No

(your doctor may help you answer some of these questions)