SLEEP HISTORY QUESTIONNAIRE

NAME:_____Date of Birth:_____

Referring Doctor:_____

Please complete page 1 & 2 now before your test.

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Choose the most appropriate number for each situation by putting an ☒ one box for each question.

Situation:		(0) Would never doze	(1) Slight chance of dozing	(2) Moderate chance of dozing	(3) High chance of dozing
1.	Sitting and reading	☐	☐	☐	☐
2.	Watching TV	☐	☐	☐	☐
3.	Sitting, inactive in a public place (eg. theatre or a meeting)	☐	☐	☐	☐
4.	As a passenger in a car for an hour without a break	☐	☐	☐	☐
5.	Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
6.	Sitting and talking to someone	☐	☐	☐	☐
7.	Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
8.	In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

OFFICE USE ONLY			
Height:	cm	BMI:	kg / m^2
Weight:	kg	Neck size:	cm
ESS:	Out of 24		

NAME: _____

OSA 50 SCREENING QUESTIONNAIRE		If yes, score
Obesity	Waist circumference* (>102 cm for males or >88 cm for females)	3
Snoring	Has your snoring ever bothered other people?	3
Apnoeas	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 measurement to be measured at the level of the umbilicus (males 102 cm = size 40 [inches] and females 88 cm = size 16)*		

To be eligible for a medicare rebate/bulk billed:

an OSA50 score of ≥5 and an Epworth Sleepiness Scale score of ≥8

STOP-Bang questionnaire

Yes	No	**Snoring?** Do you **snore loudly** (loud enough to be heard through closed doors, or your bed partner elbows you for snoring at night)?
Yes	No	**Tired?** Do you often feel **tired, fatigued, or sleepy** during the daytime (such as falling asleep during driving)?
Yes	No	**Observed?** Has anyone **observed** you **stop breathing** or **choking/gasping** during your sleep?
Yes	No	**Pressure?** Do you have or are you being treated for **high blood pressure**?
Yes	No	**Body mass index more than 35 kg/m^2?**
Yes	No	**Age older than 50 years old?**
Yes	No	**Neck size large (measured around Adam's apple)?** Is your shirt collar 16 inches or larger?
Yes	No	**Gender (biologic sex) = Male?**

Total _____

NAME: _____

What is your normal bedtime? _____

How long does it take to fall asleep? _____minutes

Do you wake during the night? ☐ Yes ☐ No

How many times? _____

If so, what wakes you? _____

Is it difficult to get back to sleep? ☐ Yes ☐ No

How long does it take? _____ minutes

What time do you finally wake in the morning? _____

What wakes you? _____

How many hours sleep do you average? _____ hours

Name:_____

Date of Birth:_____

Try to answer these questions as accurately & truthfully as possible in order for us to properly assess your sleep problems. Cross the box (□) that best represents your answer to each question. Where indicated, provide brief additional information.	ALWAYS	FREQUENTLY	OCCASIONALLY	RARELY	NEVER	UNSURE
How often do you snore?	☐	☐	☐	☐	☐	☐
Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	☐	☐	☐	☐	☐	☐
Do you wake in the night with a choking feeling?	☐	☐	☐	☐	☐	☐
Do you suffer from nasal obstruction?	☐	☐	☐	☐	☐	☐
Do you feel unrefreshed when you wake in the morning?	☐	☐	☐	☐	☐	☐
Are you often tired / sleepy during the day?	☐	☐	☐	☐	☐	☐
How often do you nap during the day?	☐	☐	☐	☐	☐	☐
Have you ever noticed drowsiness when driving a vehicle?	☐	☐	☐	☐	☐	☐
Have you had any crashes or near-miss accidents due to sleepiness when driving?	☐	☐	☐	☐	☐	☐
Do you experience restlessness or discomfort in your legs in the evening, a feeling you cannot keep your legs still?	☐	☐	☐	☐	☐	☐
Do you currently do shift work?	☐	☐	☐	☐	☐	☐
Do you drink alcohol?	☐	☐	☐	☐	☐	☐
How much and how often per week?						
Comment:						
How often do you take sleeping tablets?	☐	☐	☐	☐	☐	☐

EVENING & MORNING QUESTIONNAIRE

NAME:_ Date of Birth:_

EVENING QUESTIONNAIRE

Please answer the following questions ***before*** you go to sleep for your at-home sleep study:

1. Study Date: _____
2. Please write down the time you get into bed: _____
3. Please write down the time you turn the lights out: _____

MORNING QUESTIONNAIRE

Please answer the following questions as soon as possible when you wake after your sleep test:

1. Did any electrodes or sensors fall off during the course of the night? ☐ Yes ☐ No
   If yes, can you identify from where? _____
2. Did you drink any alcohol last evening? ☐ Yes ☐ No
   If yes, how many drinks did you have? _____
3. Did you take any medications to help you sleep last night? ☐ Yes ☐ No
   If yes, what did you take? _____
4. How long do you think it took you to get off to sleep after you switched off the lights?
   _ minutes
5. What time did you wake up this morning? _____
6. What time did you get out of bed this morning? _
7. How long do you think you slept for? _ hours
8. Did anything disturb your sleep last night? ☐ Yes ☐ No
   If yes, what disturbed you? _____
9. Please tick the box that best describes your sleep last night.
   ☐ Poor ☐ Good ☐ Very Good
10. Please tick the box that best describes how your sleep last night compares to normal.
    ☐ Worse ☐ Same ☐ Better (than usual)