PATIENT SLEEP QUESTIONNAIRE

Centurion Healthcare

Kindly return this to us via email reception@centurionhealthcare.com.au or fax to 1300 469 087.
It is important that we receive this document and a valid referral BEFORE your scheduled sleep study.

Personal Information

Surname: _____ First Name (s) _____

Date of Birth (dd/mm/yyyy): _____ Age : _____

What is your: Weight: _____kg Height: _____metres

Have you previously been diagnosed or treated with sleep apnoea? ❑ Y ❑ N

Have you had a home based sleep study done in the last 12 months? ❑ Y ❑ N

Sleep Health Questionnaire

1. Do you snore loudly
(louder than talking or loud enough to be heard through closed doors)? ❑ Y ❑ N

2. Do you feel tired, fatigued, or sleepy during daytime? ❑ Y ❑ N

3. Has anyone observed you stop breathing during your sleep? ❑ Y ❑ N

4. Do you have or are you being treated for high blood pressure? ❑ Y ❑ N

5. During sleep do you gasp/choke or experience shortness of breath? ❑ Y ❑ N

6. During sleep do you wake up to use the toilet? ❑ Y ❑ N

7. During sleep do you have regurgitation or reflux? ❑ Y ❑ N

8. Do you wake up feeling unrefreshed or have morning headaches? ❑ Y ❑ N

General Health - Please tick all that applies

Do you, or have you suffered from any of the following?

❑ Heart disease ❑ Irregular heart beat ❑ Atrial Fibrillation ❑ Heart failure ❑ High cholesterol
❑ Heart attacks ❑ Bypass surgery ❑ Arteriosclerosis ❑ Angioplasty ❑ Stent insertion
❑ Angina ❑ Stroke ❑ Vascular disease ❑ TIA ❑ Blood pressure

Do you, or have you suffered from any of the following?

❑ Diabetes ❑ Obesity ❑ Depression / Anxiety

Patient Signature

_____ _____
Signed Date

_____
Patient Name