

SLEEP DISORDER CLINIC QUESTIONNAIRE

	Date:
Name:	Tel:
	Mob:
	Occupation:

Ask your partner to help with these questions and answer all questions (Please tick answers) **Please state below main problem:** (ie Snoring/Sleepiness/ etc) **Partner available** Yes / No

SNOF 1.	RING Is it	- a)	Every i Most n Occasi	•	b)	All night Part of night		
2.	ls it	- a)	nasal	or throaty	b)	In any position On back only		
3.	Do yoι	u have	periods	where you st	op brea	athing at night?	-	never sometimes frequently <i>(State how frequently)</i>
4.	Do yoι	u have	regular	limb or body ı	movem	ents in bed at night?	-	never sometimes frequently <i>(State how frequently)</i>
5.	Do γοι	u feel s	leepy dı	uring the dayti	ime whe	en not busy? -		never sometimes often
6.	Do you	u fall as	sleep in	the daytime a	against	your will?	-	never sometimes often
7.	Do you	u have	to pull c	off the road du	ie to sle	epiness?	-	never sometimes often
8.			nost hac o sleepi	l an accident ness?	or near	miss whilst	-	never once 2 - 4 more than 4

9.	Do any factors make snoring worse (specify): e.g. cold, hayfever, alcohol.						
10.	Do you have any of the following: (Please tick) Morning headache. Very vivid dreams when going off to sleep. Nocturia (going to the loo frequently during the nig Episodes of feeling weak suddenly in the daytime A feeling of being paralysed when waking up. Resltess legs during evening.						
NASA	L SYMPTOMS:					5	
11.	Do you have any Is your catarrh Do you have any	C	- - -		/ moderate or min	/ Left side or both imal? clear or coloured?	
THRC	DAT SYMPTOMS	:			CHEST SYMPT	OMS:	
12.	Do you have:	Sore throat Difficulty swallow Voice change Dyspepsia or He	Ū	13. n	Do you have:	Cough Wheeze Shortness of breath	
14.	List here any oth pressure, Angina		al probl	ems inc	luding Cardiac pro	oblems. e.g. High blood	
15.	Family history of	sleep problems:					
16.	List past medical	problems/opera	tions:				
17.	17. List medication including Sleeping tablets, Cardiac Treatment, Lung or Nasal Sprays.						
Do you - smoke (if yes indicate how many per day)per day							
Alcoholunits per week (1 unit = 1 glass of wine a short or half a pint.)							
Norma	al Sleeping patterr	n: Time to bed			Time to ris	se	
Avera	ge number of hou	rs asleep			Quality of sl	еер	

Epworth sleepiness scale

How likely are you to doze off or fall asleep in the situations described in the box below, in contrast to feeling just 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.

Use the following scale to choose the most appropriate number for each situation:-

- $0 = \text{would } \underline{\text{never}} \text{ doze}$
- 1 = <u>Slight</u> chance of dozing
- 2 = Moderate chance of dozing
- 3 =<u>High</u> chance of dozing

Situation	Chance of dozing
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 circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
тот	AL

Thank you for your co-operation

FOR CLINIC USE ONLY:

Examination:

BP:	Weight	: Kg		Height: Cms
BMI:		St	Lbs	Ft Ins
Neck:Inches				
Nose:	septum		Mucos	Sa
Mallampati Grade:	I	II	Ш	N
Mouth:	T's		Teeth	Jaw
	Palate		Uvula	
Jaw Thrust:			Tongue Thr	ust:
FOL:				
Mullers	SG		%	
	Phar		%	
	Pal		%	
<u>Treatment Plan:</u>				

Investigations Required:

FBC	ESR	U&E	LFT	TSH	GH	Lipids
CXR	ECG	FERRITIN		Others:		