Patient Questionnaire

Please answer all the questions as best as you can.
All the information given in this form will remain confidential.

Date: ……..

Name:		
Address:		
Age: Date of Birth:	Ph Number: H) M)	Gender: (circle) Male Female Other

1. What is the main purpose of your visit today:

……

……

2. Do you have any of the following symptoms? (Circle or tick the right answers):

Respiratory

Symptoms	**Duration** (how long)?
Cough	
Sputum production	
Blood in sputum	
Shortness of breath	
Noisy breathing (wheeze)	
Chest Pain	

Sleep

Symptoms	
Snoring (during sleep)	Wake up unrefreshed
Stopping breathing (during sleep)	Daytime sleepiness/tiredness
Choking or gasping (in sleep)	Accidents due to falling asleep
Abnormal movements (in sleep)	Trouble falling asleep
Waking up for toilet >twice every night	Trouble staying asleep

3. **If you have any of the above sleep symptoms**, please answer the sleepiness scale and leg movement scales below.

- How likely are you to doze off in the following situations?

Situation	**Chance of dozing**			
	Never (0)	Slight Chance (1)	Moderate Chance (2)	High Chance (3)
Sitting and reading				
Watching TV				
Sitting inactive in a public place				
Being a passenger in a motor vehicle for one hour or more				
Lying down in the afternoon				
Sitting and talking to someone				
Sitting quietly after lunch (no alcohol)				
Stopped for a few minutes in traffic while driving				

- Tick yes or no for the following	YES	NO
Do you have uncomfortable/unpleasant sensations in the legs that cause you to move them?		
Do these symptoms get worse during rest or inactivity?		
Do these symptoms get partially or totally relieved by movements like walking or stretching		
Do these symptoms get worse during evening or night?		

4. Please provide some information regarding your personal habits and family.

Question	**Your answer**
Marital Status	
Occupation	
Work hours	
Weight and height	
Do you smoke? If yes, how many?	
Have you previously smoked?	
Alcohol Consumption	
Coffee/tea/cola consumption (per day)	
Any family history of cancer/Diabetes/Sleep apnoea/ Asthma/Cystic fibrosis/any other major illness	

5. Please list all previous medical problems, including previous surgeries and mental health problems (if any).

6. Please list all your regular medications (current)

Medication name	Medication dose	Any other details

Thank you for filling in this form.