

New Patient Form

Please take your time to answer these questions as completely as possible. It will assist us greatly in our effort to provide the best treatment for you.

Name..... Date.....

DOB..... Preferred Name..... Email.....

Home Phone..... Work..... Mobile.....

Address.....

Occupation..... Preferred method contact? Phone Email SMS

How did you hear about our practice?.....

Are you in a health fund? Yes No If yes, which one?.....

Person responsible for paying the fees.....

GP Name..... GP Phone.....

GP Address.....

Are you currently under medical care?.....

For what reason?.....

Medicare No. Reference Number..... Expiry Date.....

What is the chief complaint for which you are seeking treatment in our practice?

Please take your time to answer these questions as completely as possible. It will assist us greatly in our effort to provide the best treatment for you.

	Recent	Chronic (6 Mths+)		Recent	Chronic (6 Mths+)
Kicking or Jerking legs	<input type="checkbox"/>	<input type="checkbox"/>	Significant daytime drowsiness	<input type="checkbox"/>	<input type="checkbox"/>
Swelling in ankles or feet	<input type="checkbox"/>	<input type="checkbox"/>	Frequent heavy snoring	<input type="checkbox"/>	<input type="checkbox"/>
Morning Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Affects sleep of others	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth upon waking	<input type="checkbox"/>	<input type="checkbox"/>	Gasping when waking	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Told that "I stop breathing during sleep"	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	Night time choking spells	<input type="checkbox"/>	<input type="checkbox"/>
Tossing and turning frequently	<input type="checkbox"/>	<input type="checkbox"/>	Unable to tolerate C-PAP	<input type="checkbox"/>	<input type="checkbox"/>
Repeated awakening	<input type="checkbox"/>	<input type="checkbox"/>	Tooth grinding	<input type="checkbox"/>	<input type="checkbox"/>
Feeling unrefreshed in the morning	<input type="checkbox"/>	<input type="checkbox"/>	Teeth crowding	<input type="checkbox"/>	<input type="checkbox"/>

Any other issues you would like to discuss?

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CARDIOVASCULAR

- ☐ Heart attack
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Heart palpitations
- ☐ Heart valve disease
- ☐ Heart surgery
- ☐ Heart pacemaker
- ☐ Rheumatic fever
- ☐ Congenital heart defect
- ☐ Arrhythmias
- ☐ Aneurysm
- ☐ Other heart problems
- ☐ Irregular heart beat
- ☐ Shortness of breath
- ☐ Fluid Retention

GASTROINTESTINAL

- ☐ Stomach/Intestinal ulcer
- ☐ Colitis
- ☐ Irritable bowel syndrome
- ☐ Persistent diarrhea
- ☐ Hepatitis or liver disease
- ☐ Nausea/Vomiting
- ☐ Reflux disease
- ☐ Intestinal Disorder
- ☐ Constipation
- ☐ Gall Bladder problem/stones

ENDOCRINE

- ☐ Diabetes
- ☐ Insulin Resistance
- ☐ Hypoglycemia
- ☐ Recent Weight Gain
- ☐ Recent Weight Loss
- ☐ Thyroid disease
- ☐ Hormone replacement therapy
- ☐ Change of libido

HAEMATOLOGIC

- ☐ Blood transfusion
- ☐ Anemia
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Tendency to bleed longer than normal
- ☐ HIV
- ☐ Bruising Easily
- ☐ Tumor or Cancer
- ☐ Radiation therapy
- ☐ Chemotherapy

PULMONARY

- ☐ Allergies or hives
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic bronchitis
- ☐ Tuberculosis (TB)
- ☐ Breathing difficulties
- ☐ Sarcoidosis
- ☐ Difficulty breathing at night

SLEEP

- ☐ Frequent awakening at night
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Insomnia
- ☐ Restless legs
- ☐ Restless sleep
- ☐ Tiredness in the morning
- ☐ Feeling sleepy during the

GENITOURINARY

- ☐ Kidney, Bladder problem
- ☐ Reproductive system problem
- ☐ Ovarian Cyst
- ☐ Urinary tract Infection
- ☐ Menstrual Problems
- ☐ Kidney stones
- ☐ Renal/Kidney failure

NEUROLOGIC

- ☐ Vision problems
- ☐ Glaucoma
- ☐ Migraines
- ☐ Fainting or dizzy spells
- ☐ Stroke
- ☐ Epilepsy or seizures
- ☐ Panic attack
- ☐ Phobias
- ☐ Huntington's Disease
- ☐ Enlarge lymph nodes or gland
- ☐ Multiple Sclerosis
- ☐ Neuralgia
- ☐ Parkinson's Disease
- ☐ Nervous System Disorder
- ☐ Anxiety Disorder
- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Memory loss
- ☐ Excessive thirst
- ☐ Psychiatric Care
- ☐ Slow healing sores
- ☐ Speech difficulties

DERMAL/MUSCULOSKETAL

- ☐ Cold Sores/Herpes
- ☐ Allergy to latex (Rubber)
- ☐ Skin rash/other skin disorders
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Systemic Lupus
- ☐ Artificial (Prosthetic) joint
- ☐ Fibromyalgia
- ☐ Chronic Fatigue Syndrome
- ☐ Muscle weakness/Cramps
- ☐ Cold hands and feet
- ☐ Muscle aches
- ☐ Muscle fatigue
- ☐ Muscle spasm
- ☐ Muscle tremors
- ☐ Poor circulation
- ☐ Swollen, stiff or painful joints
- ☐ Tired muscles

Current Medications

Please list all medications you are taking and the reason you take them. Include all over the counter medications, vitamins, herbs etc

MEDICATION	DOSAGE	REASON FOR TAKING	TIME OF DAY

Personal Information

Do you drink 4 or more cups of coffee per day?	Yes	No
Do you smoke tobacco?	Yes	No
Do you consume alcohol or take sedatives?	Yes	No
Do you take recreational drugs?	Yes	No
Do you have allergies or intolerance to any medications, foods or Environmental factors?	Yes	No
If so, please list.....		
In the last year, have you drunk alcohol or used drugs more than you meant to?	Yes	No
Have you felt you need to cut down on your drinking or drug use in the last year	Yes	No

Family History

Have any family members had heart disease/high blood pressure/diabetes?	Yes	No
Do any family members snore, or have OSA or a sleep disorder?	Yes	No
If yes, who?		

Current Medications

Please select Yes or No answers based on your average sleep experience and/or what a sleep partner has told you

Sleep Positions:	Side	Back/Stomach/Varies
Is it easy to fall asleep?	Yes	No
How long does it take you to fall asleep in bed?.....		
How many hours sleep do you obtain each night?.....		
Do you feel rested upon AM waking?	Yes	No
Have you been told you stopped breathing and gasp during sleep?	Yes	No
Do you wake often during the night?	Yes	No
Do you have difficulty falling asleep again overnight after awakening?	Yes	No
Do you wake up refreshed the next day?	Yes	No
Do you often wake feeling tired?	Yes	No
Do you grind or clench your teeth in your sleep?	Yes	No
Do you often wake in the morning with a headache?	Yes	No
Do you feel pain in your jaw joints (in front of the ear)?	Yes	No
Do you have problems concentrating for long periods of time?	Yes	No
Have you ever had a Sleep Study (PSG)?	Yes	No
If so, what was the result?.....		

Additional Sleep Apnea Symptoms

Sore, dry throat on waking	Yes	No
Morning headache	Yes	No
Nycturia (Having to get up to pass urine repeatedly)	Yes	No
Decreased sex drive or impotence	Yes	No
Gastro-esophageal reflux	Yes	No
Personality changes, which may include irritability	Yes	No
Decreased job performance	Yes	No
Choking or gasping during sleep	Yes	No
Anxiety or depression	Yes	No
Poor concentration/memory	Yes	No
Have you got any of the following:		
High blood pressure	Type 2 diabetes	Atrial fibrillation Congestive heart failure

Berlin Questionnaire

Category 1

1. Do you snore?

Yes No Don't know

2. Your snoring is

Slightly louder than breathing as loud as talking Louder than talking very loud can be heard in adjacent room

3. How often do you snore?

Nearly every night 3-4 times a week 1-2 times a week 1-2 times a month never

4. Has your snoring ever bothered other people?

Yes No Don't know

5. Has anyone noticed that you stop breathing during your sleep?

Nearly every night 3-4 times a week 1-2 times a week 1-2 times a month never

Category 2

6. How often do you feel tired or fatigued after your sleep?

Nearly everyday 3-4 times a week 1-2 times a week 1-2 times a month never

7. During your wake time, do you feel tired, fatigued or not up to par?

Nearly everyday 3-4 times a week 1-2 times a week 1-2 times a month never

8. Have you ever nodded off or fallen asleep while driving a vehicle?

Yes No

9. If yes, how often has

Nearly every night 3-4 times a week 1-2 times a week 1-2 times a month never

Category 3

10. Do you have high blood pressure?

Yes No Don't know

Epworth Sleepiness Scale

(How likely are you to fall asleep in the following situations?)

0 = no chance of dozing 1 = slight chance of dozing 2 = moderate chance 3 = high chance

Situation	Chance of dozing (0 - 3)
Sitting and Reading	
Sitting inactive in a public place (eg theatre/meeting)	
As a passenger in a car for an hour without a break	
Sitting quietly after lunch without alcohol	
Watching TV	
Lying down to rest in the afternoon (when circumstances permit)	
Sitting and talking to someone	
In a car, while stopped for a few minutes in traffic	

Total score _____

Office Use Only

History of missing teeth:	
Extractions:	
Premature birth:	
Hypermobility:	