PATIENT REGISTRATION FORM

**Please complete both sides and return it to Receptionist*

First Name: _____ Last Name: _____

Residential Address: _____

Suburb: _____ State: _____ Postcode: _____

Email: _____

Phone Number: _____ Mobile Number: _____

Date of Birth: _____ Age: _____ Medicare number: _____ Exp. _____

DVA Number _____ Pension/Health/Student Number _____

Private Health Fund _____ Number _____

Occupation: (current/previous): _____

Marital Status: _____ Number Children: _____ Hobbies: _____

Emergency Contact Name: _____ Phone No.: _____

Name and Address of your GP: _____

_____

Name and Address of other practitioners involved with your care that require a copy of your correspondence:

_____

Q1. Do you smoke? Yes / No **Q2. Have you ever smoked?** Yes / No

If Yes, maximum smoked per day: _____ Year started: _____ Year stopped: _____

Q3. Passive smoke exposure: Light / Heavy

Q4. Alcohol Consumption (average per day- standard drinks): _____

Q5. Current Medications (Please list all details):

Medication and Dose:	*Reason:*	*Year Commenced:*

Q5b. List any illnesses or operations you have had:

Illness:	*Year Commenced:*

Q6. Please list any drug allergies / reactions to anaesthetics that you have had:

Drug:	*Type of Reaction:*

Q7. Have you received the following vaccinations? If so, when?

Flu Vaccine: _____ Pneumovax: _____ BCG Vaccine (for Tuberculosis: _____

Q8. Has there been any past exposure to:

TB (Tuberculosis) / Asbestos: Yes / No Other noxious fumes and dusts (for prolonged periods) Yes / No

Q9. Is there any major health related illness in your family? (e.g. Communicable disease, Heart disease, Diabetes, Cancer, Sleep Apnoea or heavy snoring). If so, please list below.

_____

Signed: _____ Date: _____

Name of Patient: _____ DOB: _____

Q10. Are you exposed to pets or birds? If so, describe the exposure.

_____

Q11. Have you traveled overseas recently? If yes, please describe and include dates.

_____

Q12. When did you last have:

1. Chest x-ray: _____
2. Blood Tests: _____

Q13. How far can you walk at a steady pace? _____ or Unlimited

Q14. Have you had a home-based sleep study in the last 12 months? Yes / No

Please Fill In The Following Sleep Related Questions:

1. Usual time of Going to Sleep _____
2. Usual time of Waking Up. _____
3. How long does it take to fall asleep _____
4. Do you awaken frequently at night (?toilet, etc) _____
5. Is your sleep refreshing? Yes / No
6. Do you wake with a dry throat? Yes / No
7. Are your legs restless at night? Yes / No
8. Do you have caffeine at night? Yes / No
9. Do you snore heavily? Yes / No
    a. If so, is it worse after alcohol? Yes / No
    b. If so, is it worse on your back? Yes / No
10. Have you been observed to stop breathing? Yes / No
11. Do you feel a choking sensation when sleeping? Yes / No
12. Do you wake up with headaches? Yes / No
13. Do you feel sleepy driving? Yes / No
14. Have you had problems with memory or concentration? Yes / No

Q15. Please rate your chance of dozing in the following situations:

Score

0 No chance**;** **1** Slight**;** **2** Moderate**;** **3** High Chance

a. Sitting and Reading ____
b. Watching TV ____
c. Sitting inactive in a public place ____
d. Passenger in a car ____
e. Lying down to rest in p.m. ____
f. Sitting and Talking ____
g. Sitting quietly after lunch (nil alcohol) ____
h. In car, stopped in traffic ____

Signed: _____ Date: _____