|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Sleep Disorder Centre** | QVH Trust RGB BLUE - Copy |  |  |  |  |  |  |  |  |  |  |
| Direct Line 01342 305420Email:  qvh.sleepdisordercentre@nhs.net**Consultants:**Dr Mark Jackson MB FRCP Clinical LeadDr Praveen Molanguri FRCPProfessor Adrian Williams FRCP AASMDr Susanna Ng MB ChB MRCP FRCP Edin |  | Holtye Road | East Grinstead | West Sussex | RH19 3DZ01342 414000 | qvh.info@nhs.netwww.qvh.nhs.uk |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

**GENERAL MEDICAL QUESTIONNAIRE**

**INSOMNIA**

**A. Patient Details**

**Name: …………………………………………………… DOB: ………………………………….…..…..**

**Address: ……………………………………………………………………………………………….…………..**

**…………………………………………………………… Postcode: ………………………………..........**

**Daytime Tel No: ……………………………………… …. Evening Tel No: ………………………………**

*We are now sending text reminders of appointments – if you do*

*not wish to receive such texts, please tick the box*

**Mobile Tel No: ………………………………………… E-mail address: ………………………………**

**In case of emergency contact: Name: ……………………..…………. Tel: ………………….……….**

**GP and Address: …………………………………………………………………………………………...............**

**GP Tel No: …………………………………………………. Your Occupation: ……………………………..**

**B. Do you have or have you suffered from any of the following:**

Please answer ALL of the following questions by ticking the appropriate box & circling the appropriate condition

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** |  | **No** |
| 1. Heart disease/Rheumatic Fever
 |  |  |  |
| 1. Palpitations/chest pain at rest (……….) on exertion (………..)
 |  |  |  |
| 1. High blood pressure
 |  |  |  |
| 1. Undue shortness of breath on exertion (……….) at rest (………) lying flat (………)
 |  |  |  |
| 1. Respiratory Disease - Bronchitis/Asthma /COPD
 |  |  |  |
| 1. Arthritis or muscle disease/neck or back problems
 |  |  |  |
| 1. Diabetes - Type 1/Type 2
 |  |  |  |
| 1. Epilepsy/stroke/blackouts
 |  |  |  |
| 1. Hepatitis/Jaundice
 |  |  |  |
| 1. Urinary or kidney problems
 |  |  |  |
|  |  |
| 1. Anxiety Disorders
 |  |  |  |
| 1. Thyroid problems - Hypothyroidism/Hyperthyroidism
 |  |  |  |

**C. Please list any previous operations, serious illnesses or chronic medical conditions**

 Operation, illness, condition Date

 ………………………………………………….. ……… …………………………………..

 ………………………………………………….. ……… …………………………………..

**D. Medication:**

|  |  |  |  |
| --- | --- | --- | --- |
|   | **Yes** |  | **No** |
|  Are you currently taking any drugs, medicines or tablets?  |  |  |  |

 Including the contraceptive pill, sleeping pills, painkillers, aspirin and inhalers.

 If ‘Yes’, please list

 ……………………………………………………………………………………………………………………………

 ……………………………………………………………………………………………………………………………

 **Please bring repeat prescription with you if applicable.**

**E. Have you ever had any allergic reactions to or known allergies to:**

|  |  |  |  |
| --- | --- | --- | --- |
|   | **Yes** |  | **No** |
| 1. Drugs/Medications (eg Penicillin)

  |  |  |  |
| 1. Other substances? (eg Plasters/Rubber/Latex)
 |  |  |  |

 **Please list: ……………………………………………………………………………**

|  |  |  |  |
| --- | --- | --- | --- |
| **F. Do you smoke?**  | **Yes** |  | **No** |
| How long have you smoked**? ………………………………………………………** |  |  |  |

What and how many per day? **………………………………………………………**

|  |  |  |  |
| --- | --- | --- | --- |
| **G. Do you drink alcohol?**  | **Yes** |  | **No** |
| How many units per week? **……………………………………………………..**1 unit = small glass of wine or half pint of beer or cider or 1 small measure of spirit |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Weight now?** |  |  **Are you married?** **or**  | Yes? | *Please**tick* | No? |
|  |  |  |  |  |  |
| **Weight when married?** |  |  **Do you have a partner?** **or**  | Yes? | *Please**tick* | No? |
|  |  |  |  |  |  |
| **Height?** |  |  **Are you single?** | Yes? | *Please**tick* | No? |
|  |  |  |  |  |  |
| **Collar size (if known)** |  |  **How long have you**  **been together?** |  |

**IF YOU NEED TO COME IN FOR AN INPATIENT STAY THE FOLLOWING QUESTIONS WILL HELP US ENSURE THAT WE PROVIDE EVERYTHING YOU NEED**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| 1. **Are you a wheelchair user?**
 | **Yes** |  | **No** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Do you have any equipment which you need to bring with you to aid you? If yes, please give details:**
 | **Yes** |  | **No** |  |

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Do you have a carer who needs to accompany you and stay**
 | **Yes** |  | **No** |  |

 **overnight?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Do you have a history of blackouts, falls or fits?**
 | **Yes** |  | **No** |  |

|  |  |  |
| --- | --- | --- |
| 1. **How many times, on average, do you get up in the night to use the toilet?**
 |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Have you had recent episodes of sleepwalking?**
 | **Yes** |  | **No** |  |

 If yes, how frequently does this occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Do you have any of the following?**

**Speech difficulties** | **Yes** |  | **No** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Hearing difficulties** | **Yes** |  | **No** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Language difficulties** | **Yes** |  | **No** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Visual difficulties** | **Yes** |  | **No** |  |
|  |  |  |  |  |
| **Learning or comprehension difficulties** | **Yes** |  | **No** |  |

 If you answered yes to any of the above, please give details:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Have you ever been diagnosed with MRSA?**
 | **Yes** |  | **No** |  |

 If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you now been tested clear? | **Yes** |  | **No** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Do you have any infectious diseases which could be**
 | **Yes** |  | **No** |  |

 **transferred to others?** If yes, please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| 1. **If a member of staff were to wake you in the night how would you react?**
 |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Do you have any other specific needs (eg religious, personal) that we should consider during your stay?**
 | **Yes** |  | **No** |  |

 If yes, please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THE EPWORTH SLEEPINESS SCALE**

Name: .......................................................................................................................………..

Your age (Yrs): .............. Sex: Male / Female Date: ........................………….

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

Even if you haven't done some of these things recently, try to work out how they would have affected you.

Using the following scale to choose the most appropriate number for each situation, please fill in the left hand column and ask your partner to fill in the right hand column:-

 0 = would never doze

 1 = Slight chance of dozing

 2 = Moderate chance of dozing

 3 = High chance of dozing

|  |  |
| --- | --- |
|  | Chance of dozing |
| Situation | Patient | Partner’s Assessment of Patient |
| Sitting and reading |  |  |
| Watching TV |  |  |
| Sitting, inactive in a public place (eg 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 |  |  |

Thank you for your co-operation

**GAD-7**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Over the last 2 weeks, how often have you** **been bothered by the following problems?***(Use “✔” to indicate your answer”* | Not at all | Several days | More than half the days | Nearly every day |
| 1. Feeling nervous, anxious or on edge
 | 0 [ ]  | 1 [ ]  | 2 [ ]  | 3 [ ]  |
| 1. Not being able to stop or control worrying
 | 0 [ ]  | 1 [ ]  | 2 [ ]  | 3 [ ]  |
| 1. Worrying too much about different things
 | 0 [ ]  | 1 [ ]  | 2 [ ]  | 3 [ ]  |
| 1. Trouble relaxing
 | 0 [ ]  | 1 [ ]  | 2 [ ]  | 3 [ ]  |
| 1. Being so restless that it is hard to sit still
 | 0 [ ]  | 1 [ ]  | 2 [ ]  | 3 [ ]  |
| 1. Becoming easily annoyed or irritable
 | 0 [ ]  | 1 [ ]  | 2 [ ]  | 3 [ ]  |
| 1. Feeling afraid as if something awful might happen
 | 0 [ ]  | 1 [ ]  | 2 [ ]  | 3 [ ]  |

 **Column Totals: \_\_\_\_\_\_ + \_\_\_\_\_\_ + \_\_\_\_\_\_ + \_\_\_\_\_\_**

 **= Total Score \_\_\_\_\_\_\_\_**

The Sleep Condition Indicator

|  |  |
| --- | --- |
|  | Score |
| Item | 4 | 3 | 2 | 1 | 0 |
| ***Thinking about a typical night in the last month …*** 1. … how long does it take you to fall asleep?
 | 0 – 15 min | 16 – 30 min | 31 – 45 min | 46 – 60 min | ≥ 61 min |
| 1. … if you then wake up during the night … how long are you awake for in total?

(add all the wakenings up) | 0 – 15 min | 16 – 30 min | 31 – 45 min | 46 – 60 min | ≥ 61 min |
| 1. … how many nights a week do you have a problem with your sleep?
 | 0 - 1 | 2 | 3 | 4 | 5 - 7 |
| 1. … how would you rate your sleep quality?
 | Very good | Good | Average | Poor | Very poor |
| ***Thinking about the past month, to what extent has poor sleep …***1. … affected your mood, energy, or relationships?
 | Not at all | A little | Somewhat | Much | Very much |
| 1. … affected your concentration, productivity, or ability to stay awake
 | Not at all | A little | Somewhat | Much | Very much |
| 1. … troubled you in general
 | Not at all | A little | Somewhat | Much | Very much |
| **Finally …**1. … how long have you had a problem with your sleep?
 | I don’t have a problem / < 1 mo | 1 – 3 mo | 3 – 6 mo | 6 – 12 mo | > 1 yr |

Scoring instructions:

1. Add the item scores to obtain the SCI total (minimum 0, maximum 32)
2. A higher score means better sleep
3. Scores can be converted to 0 – 10 format (minimum 0, maximum 10) by dividing total by 3.2
4. Item scores in grey area represent threshold criteria for DSM-5 Insomnia Disorder

A free online version, with built-in score convertor, available at [www.sleepio.com/SCI](http://www.sleepio.com/SCI)



Dear Patient,

All NHS Trusts are required by the Government to collect the ethnic category of each of their patients. This will help to identify the varying needs of the different communities and highlight any areas where there is a shortfall in service provision. On a more practical level, it can be used to implement multi-language signs and help provide food suitable for the needs of different ethnic groups.

This information is **STRICTLY CONFIDENTIAL** and will only be used by authorised staff. Please circle the letter which relates to your ethnic group.

Please return this letter with your questionnaire or hand it back to a member of staff.

Thank you for your time.

|  |  |  |  |
| --- | --- | --- | --- |
| **Date:** |  | **Hospital Number** |  |
|  |  |
| A | [ ] White - British  |
| B | [ ]  White -Irish |
| C | [ ]  White - Any other White background |
| D | [ ]  Mixed - White & Black Caribbean |
| E | [ ]  Mixed - White & Black African |
| F | [ ]  Mixed - White & Asian |
| G | [ ]  Mixed - Any other mixed background |
| H | [ ]  Asian or Asian British - Indian |
| J | [ ]  Asian or Asian British - Pakistani |
| K | [ ]  Asian or Asian British - Bangladeshi |
| L | [ ]  Asian or Asian British - Any other Asian background |
| M | [ ]  Black or Black British - Caribbean |
| N | [ ]  Black or Black British - African |
| P | [ ]  Black or Black British - Any other Black background |
| R | [ ]  Other ethnic groups - Chinese |
| S | [ ]  Other ethnic groups - Any other ethnic group |

Sleep Disorder Centre Co-Ordinator

**When completed please save this document to your device, and if you would prefer, you can email this form to** **tqv-tr.qvhsleepinformation@nhs.net**

**Please be advised this is not considered a secure method of communication/transfer and is used at your own risk.**