For what sleep-related diagnosis are you being followed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What therapy or medication are you receiving for your sleep related diagnosis?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you having any problems that you want to discuss with your doctor today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you developed any new medical problems since your last visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been hospitalized or had any surgeries since your last visit here? □ No □ Yes

If yes, please list and explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your typical Sleep Schedule on work days? Bedtime:\_\_\_\_\_ Rise time:\_\_\_\_\_ How long to fall asleep?\_\_\_\_\_

What is your typical Sleep Schedule on off days? Bedtime:\_\_\_\_\_ Rise time:\_\_\_\_\_ How long to fall asleep?\_\_\_\_\_

Do you take naps? □ No □ Yes If so, how many days per week? \_\_\_\_\_

|  |
| --- |
| **Section only for patients who use PAP equipment** |
| Related to your PAP equipment use, do you have any of the following symptoms?  □ Nasal Irritation □ Nasal Congestion □ Nasal Dryness □ Dry Mouth □ Bloating or Gas  □ Breathing Difficulties □ Skin Irritation □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you use PAP machine nightly? □ No □ Yes If not, is there a reason why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you snore or stop breathing when you wear your PAP? □ No □ Yes  Do you feel better when using your PAP? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you use your PAP when you nap? □ No □ Yes  When you go on trips, do you take your PAP machine with you? □ No □ Yes  Are you having any problems with any of your equipment? □ No □ Yes If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **EPWORTH SLEEPINESS SCALE -** Please estimate your risk of falling asleep in the following situations, using the scale below. | |
| **SITUATION** | **CHANCE OF DOZING** |
| Sitting and Reading | □ 0= None □ 1 = Slight □ 2 = Moderate □ 3=High |
| Watching TV | □ 0= None □ 1 = Slight □ 2 = Moderate □ 3=High |
| Sitting inactive in a public place (e.g. theatre or meeting) | □ 0= None □ 1 = Slight □ 2 = Moderate □ 3=High |
| As a passenger in a car for an hour without a break | □ 0= None □ 1 = Slight □ 2 = Moderate □ 3=High |
| Lying down to rest in the afternoon when circumstances permit | □ 0= None □ 1 = Slight □ 2 = Moderate □ 3=High |
| Sitting and talking to someone | □ 0= None □ 1 = Slight □ 2 = Moderate □ 3=High |
| Sitting quietly after a lunch without alcohol | □ 0= None □ 1 = Slight □ 2 = Moderate □ 3=High |
| In a car, while stopped for a few minutes in traffic | □ 0= None □ 1 = Slight □ 2 = Moderate □ 3=High |
| **MEDICATION OR NON-MEDICATION ALLERGIES** | |

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

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

\*If any of these allergies have recently been identified, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **SOCIAL HISTORY** |

Do you currently smoke? □ No □ Yes Did you used to smoke? □ No □ Yes If so, when did you quit? \_\_\_\_\_

Do you drink alcohol? □ No □ Yes If yes, how many drinks per week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently use recreational drugs? □ No □ Yes Have you used recreational drugs in the past? □ No □ Yes

Do you drink coffee, caffeinated sodas, energy drink or teas? □ No □ Yes If so, how many cups per day? \_\_\_

Do you exercise regularly? □ No □ Yes How many days per week? \_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **REVIEW OF SYSTEMS** |

Please check box if you have had any of the following in the past several weeks. **Check here if all negative** □

|  |  |  |
| --- | --- | --- |
| **General:**  □ Fevers or sweats  □ Weight gain or loss \_\_\_\_\_ lbs  **Neurologic:**  □ Passing out  □ Numbness or tingling  □ Headache  **Psychiatric:**  □ Depression  □ Anxiety  □ Stressful life event | **Ear, Nose, Throat:**  □ Sinus Congestion  **Respiratory:**  □ Trouble breathing  □ Coughing or wheezing  **Musculoskeletal:**  □ Back pain  □ Muscle aches or cramps  □ Joint pain  **Genitourinary:**  □ Frequent urination | **Cardiovascular**:  □ Chest discomfort  □ Rapid or skipped heart beats  **Endocrine:**  □ Heat or cold intolerance  □ Menopausal symptoms  □ Thyroid Problems  **Gastrointestinal:**  □ Nausea or vomiting  □ Heartburn |

|  |
| --- |
| **PHYSICIAN USE ONLY** |
| NOTES: |
| PROBLEM: |
| PLAN: |