

Name: _____ DOB: _____ Age: _____ Date: _____ Requesting/Primary Physician: _____

Please help us find out about you by filling out the "Patient" side of this form on pages 1-6. If you don't know the answer to one of the questions, ask your bed partner if he/she can answer it for you.

Please leave "Clinician" side blank.

SLEEP PATIENT	CLINICIAN
----------------------	------------------

Why are you here to see a sleep specialist?

CC

If you are already on CPAP go to page 2

Do you snore?

- Yes No Don't know

If yes, is it loud?

- Yes No Don't know

In which position do you snore?

- Back All Don't know

Does it disturb anyone?

- Yes No Don't know

What is your collar size? _____

Has anyone ever noticed if you stop breathing in your sleep?

- Yes No

Do you gasp or choke while you sleep?

- Yes No

Do you suffer from either of the following in the morning?

- Dry mouth Headache

Do you feel sleepy during the daytime?

- Yes No Don't know

How many days per week? _____

When did it start? _____

Is it worsening?

- Yes No Don't know

Please continue on page 3.

Office Procedures for Today's Visit:

Ordered	Completed
<input type="checkbox"/> Full PFTs	<input type="checkbox"/>
<input type="checkbox"/> Pre/Post Spirometry	<input type="checkbox"/>
<input type="checkbox"/> 6 MWT with O2 Titration	<input type="checkbox"/>
<input type="checkbox"/> SpO2	<input type="checkbox"/>
<input type="checkbox"/> Inhaler Training	<input type="checkbox"/>
<input type="checkbox"/> PA/LA CXR	<input type="checkbox"/>
<input type="checkbox"/> CT Chest	<input type="checkbox"/>
<input type="checkbox"/> Influenz vaccination	<input type="checkbox"/>
<input type="checkbox"/> INR Check	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>

Do wear CPAP?

Yes No

If no please explain why: _____

HPI

How many nights per week? _____

How many hours a night? _____

Have you been told you snore while wearing CPAP

Yes No

Any problems with:

Dry throat?

Yes No

Morning headache:

Yes No

Bloating and gas in the morning?

Yes No

Nasal congestion

Yes No

Do you take daytime stimulants?

Yes No If so what kind? _____

Do you take sleeping pills ?

Yes No If so what kind? _____

What kind of mask do you use?

Nasal pillow _____

Nasal mask _____

Full face mask _____

When did you last get a new mask? _____

Please continue on next page. _____

PATIENT

CLINICIAN

Have you ever had a close call, drowsiness or accident when driving because of sleepiness?

- Yes No Don't know

Do you suffer from memory problems?

- Yes No

Do you find it difficult to focus or concentrate?

- Yes No

Do you take any daytime naps?

- Yes No

How many per week?

How long, on average, do they last?

Are the naps refreshing?

- Yes No

Are you irritable lately?

- Yes No

Have you been feeling depressed or overly anxious?

- Yes No

Have you been told by a health care professional that you may suffer from depression?

- Yes No

Rate the severity of your sleepiness on a scale of 1 to 10. (1 being no sleepiness and 10 being very severe sleepiness) _____

Do you ever experience restlessness or discomfort in your legs?

- Yes No When? _____

What do you do to relieve it?

How often does it occur? _____

Does it interfere with sleep? _____

- Yes No

Do you move or kick your legs while sleeping?

- Yes No

Do you take medications for restless legs?

- Yes No If so which medication? _____

Have you ever felt the sudden loss of strength

(arms, legs) in response to some emotional experience?

- Yes No

Have you ever felt paralyzed when you first wake up or falling asleep?

- Yes No

Do you ever dream while you are falling asleep or napping?

- Yes No

Do you ever accidentally urinate in bed?

- Yes No

Do you walk or talk in your sleep?

- Yes No

Do you have nightmares?

- Yes No

Tell us about your sleep schedule:

What is your bedtime? _____ **Start**

How long does it take you to fall asleep? _____

When do you wake up? _____

Do you feel refreshed? _____

When do you wake up on weekends & days off? _____

_____ Feel better if sleep longer? _____

Do you wake up in the middle of the night?

Yes No **If yes do you look at the clock** _____

How many times per night? _____

Do you fall asleep again easily?

Yes No

How many times a night do you go the bathroom?

Do you lie in bed not being able to sleep?

Yes No

Do you watch TV in bed ?

Yes No

When sleeping away from home do you sleep better or worse?

Better Worse

Tell us about your daytime schedule:

What is your occupation and work hours? _____

Are you a commercial driver? ___Yes ___ No

How likely are you to doze off or fall asleep in the following situations?

Please use the following scale:

- 0 *Would never doze*
- 1 *Slight chance of dozing*
- 2 *Moderate chance of dozing*
- 3 *High chance of dozing*
- ___ **Sitting and reading**
- ___ **Watching television**
- ___ **Sitting inactive in a public place**
- ___ **While a passenger in a car without a break**
- ___ **Laying 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 in traffic for a few min.**

Has your weight changed ? ___ Increased ___ Decreased

Have you ever had any operations?

- 1 _____
- 2 _____
- 3 _____
- 4 _____

PAST FAMILY SOCIAL HISTORY

Epworth Score: _____

Past Surg Hx

PMH

Do you have high blood pressure?

- Yes No

Have you ever had a stroke or heart attack?

- Yes No If yes when _____

Do you suffer from angina?

- Yes No

Do you have a cough?

- Yes No

Do you get short of breath?

- Yes No

Have you ever been diagnosed with Asthma or COPD?

What other medical problems do you have?

List your current medications?

Medications:

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

Check if any close family member (parents, brothers and sisters, children) have:

- Heart Problems
- High Blood Pressure
- Diabetes
- Cancer
- Heartburn
- Obstructive Sleep Apnea

Family Hx

Are there any other health problems in your family?

Do you have any allergies?

- Yes No

PATIENT **CLINICIAN**

Marital Status S M W D

Do you currently smoke?

- Yes No If yes how long _____ How much _____

Social Hx

Have you ever smoked?

- Yes No If yes how long _____ How much _____

Do you drink alcoholic beverages?

- Yes No

Do you currently use recreational drugs?

- Yes No

Do you drink:

- How much per day
- coffee _____
 - tea _____
 - soda _____
 - energy drinks _____

With whom do you live?

What is your occupation?

What are your leisure activities?

What is your education level?

PATIENT	REVIEW OF SYMPTOMS
<i>Please circle any symptom you have, so we can find out more about it:</i>	
Lack of energy; daytime sleepiness; trouble sleeping; snoring; loss of appetite; weight changes; fevers	Constitutional
Eye problems, such as double or blurred vision; glaucoma; cataracts	HEENT
Hearing problems; buzzing or ringing in ears	
Allergies; hay fever	
Sinus problems	
Blood pressure or heart problems	Cardiac
Asthma; tuberculosis	Pulmonary
Stomach problems; heartburn; indigestion; change in bowel habits	Digestive
Bloody or tarry stools; jaundice; liver problems; ulcers; gallstones	
Urinary problems: Frequency; infections; stones; bladder	Urinary
Men: Prostate problems; night-time urination	
Women: Abnormal menstrual periods; could you be pregnant?	
Joint pains swelling or redness; arthritis; back pain	Musculoskeletal
Muscle aches or tenderness; gout	
Rash, itching or other skin problems	Dermatological
Women: breast lumps; recent mammogram, pap smear and/or pelvic exam	Female Reproductive
Paralysis (even temporary); stroke; numbness; loss of balance	Neurological
Seizures; loss of memory; headaches	
Unusual thoughts; nervousness; crying or sadness; depression	Psychiatric
Suicide attempts	
Thyroid disorder; diabetes; excess thirst; hunger or urination	Endocrinology
Bleeding; easy bruising; risk factors for HIV; anemia; cancer	Hematological

The above history information was obtained by or personally reviewed by me. I agree with or have amended it's findings.

Physical Exam

General Appearance _____ Today's Wt _____ Last Wt _____ Ht _____	
Pulse _____ BP _____ BMI _____	
Respirations _____ Neck Circumference _____ Pulse Oximetry _____ (_____)	
N=Normal A=Abnormal D=Deferred	
1) NOSE Mucosa _____ Turb _____ Septum _____	Abnormal Findings malam 1 2 3 4 retrognathia Y N
2) MOUTH Mucosa _____ Teeth _____ Gums _____ Posterior Pharynx _____ Palate- Hard _____ Soft _____ Tongue _____ Tonsils _____	
3) NECK Appearance _____ Masses _____ Symmetry _____ Trachea Position _____ Crepitus _____ Thyroid _____ JVD _____	Inches _____
4) RESP Inspect _____ Symmetry _____ Effort _____ Percussion _____ Palpation _____ Ausc _____	
5) HEART Apex _____ Heave _____ Thrill _____ Sounds _____ Murmur _____ Rub _____	
6) ABDOMEN Masses/Tenderness _____ Liver _____ Spleen _____ Bowel Sounds _____	
7) LYMPH Neck _____ Axillae _____ Groin _____ Other (Specify) _____	
8) MUSCULOSKELETAL Gait _____ Station _____ Strength _____ Tone _____ Atrophy _____ Abnor. Movement _____	
9) EXTREMITIES Varicosities _____ Edema _____ Pulses _____ Temp _____ Tenderness _____ Digits _____ Nails _____	
10) SKIN _____ (Describe scars, rashes, etc.)	
11) NEUROPSYCH Oriented _____ Mood _____	

	Office/Hospital Consult
1-5 Bullet Points	99241/99251
6-11 Bullet Points	99242/99252
12-17 Bullent Points	99243/99253
All Items with Gray Border	99244/99254
and 1 Item in each Non-	99245/99255

Decision Making

- Lab (Date)
 - Thyroid Studies _____
 - Lytes _____
 - BUN/Cr _____
- ABG _____
- Other (Specify) _____
- Pulmonary Function Studies - Specify Date _____
- Other (List/Date) _____

X-Rays (Date)

Physician Interpretation:

IMPRESSION:

Office Procedures to be done on RTC Scheduled

- | | | |
|--|---------------------------------------|--------------------------|
| <input type="checkbox"/> PFT's | <input type="checkbox"/> ATS Criteria | <input type="checkbox"/> |
| <input type="checkbox"/> Pre/Post Spirometry | | <input type="checkbox"/> |
| <input type="checkbox"/> 6 MWT with O2 Titration | | <input type="checkbox"/> |
| <input type="checkbox"/> PALAT CXR | | <input type="checkbox"/> |
| <input type="checkbox"/> Other | | <input type="checkbox"/> |

PLAN:

Physician Signature

Medical Decision Making

DATA REVIEWED:

Lab (Date)

- Thyroid Studies _____ Lytes _____ BUN/Cr _____
 ABG _____
 Other (Specify) _____

Pulmonary Function Studies - Specify Date _____

FEV₁ _____%(_____) FVC _____%(_____) TLC _____%(_____) DLCO _____%(_____)

Other (List/Date) _____

IMPRESSION:

- F/U _____
 Diagnostic NPSG
 Split NPSG/CPAP
 CPAP Titration
 MSLT
 Conditional MSLT
 Nocturnal Pulse Ox
 SNAP Test
 Lab _____

PLAN:

- ENT Referral _____
 Dental Referral for OA _____

Physician Signature