

MidState
PULMONARY

SLEEP CLINIC NEW PATIENT NOTES

DR. RICH TYSON

DR. JORDAN PHILLIPS

Name: _____ Date: _____

Age: _____ DOB: _____ Gender: M F Referring Provider: _____

Temp: _____ BP: _____ HR: _____ RR: _____ O₂ Sat ___ on RA oxygen _____ lpm

Weight: _____ lbs Height: _____ inches BMI: _____ Neck circumference: _____ inches

Thank you for visiting the clinic today. Please answer the questions below. Thank you.

What time do you usually get into bed? _____

How long does it typically take you to fall asleep? _____

How many times do you typically wake up between bedtime and getting out of bed in the morning? _____

What time do you typically get out of bed? _____

Do you usually feel rested when you wake up in the morning? _____

Do you experience morning headaches? _____

Do you have trouble staying awake during the day (excessive daytime sleepiness)? _____

EPWORTH SLEEPINESS SCALE: How likely is it that you would doze off or sleep in the following situations?

0 = would never doze or sleep. 1 = slight chance of dozing or sleeping. 2 = moderate chance of dozing or sleeping.

3 = high chance of dozing or sleeping.

SITUATION

Sitting and reading

Watching TV

Sitting inactive in a public place

Being a passenger in a motor vehicle for an hour or more

Lying down in the afternoon

Sitting and talking to someone

Sitting quietly after lunch (no alcohol)

Stopped for a few minutes in traffic while driving

CHANCE OF DOZING OR SLEEPING

0 1 2 3

0 1 2 3

0 1 2 3

0 1 2 3

0 1 2 3

0 1 2 3

0 1 2 3

0 1 2 3

Total score (add up the scores). This is your Epworth score: _____

Do you snore loudly? Y N

Have you been told that you "stop breathing" and make loud snoring, gasping, or choking sounds? Y N

Do you nap? Y N If yes, for how long _____, how often _____, at approximately what time _____?

What is your employment? _____

Do you work shifts? Y N If yes, please describe: _____

Do you smoke? Y N If yes, how many packs/day _____, for how many years _____?

Do you drink caffeinated beverages? Y N If yes, how many per day? _____

Do you drink alcohol? Y N If yes, how many drinks per day? _____

Do you use any prescription or over the counter sleep medicines? _____

For MD use: Reviewed with patient (initial) _____

PHYSICIAN NOTES

Empty box for physician notes.