MidState
PULMONARY

SLEEP CLINIC FOLLOW-UP ■ DR. RICHARD TYSON

Patient Name: _____

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

Who referred you to see Dr.Tyson? _____

Who is your primary care provider? _____

What time do you usually get into bed? _____

How long does it usually 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 usually get out of bed? _____

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

Do you experience morning headaches? _____

EPWORTH SLEEPINESS SCALE: How likely is it that you would doze off or sleep in the following situations?
0 = never **1** = slight chance. **2** = moderate chance **3** = high chance

SITUATION	CHANCE OF DOZING OR SLEEPING
Sitting and reading	☐ 0 ☐ 1 ☐ 2 ☐ 3
Watching TV	☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting inactive in a public place	☐ 0 ☐ 1 ☐ 2 ☐ 3
Being a passenger in a motor vehicle for an hour or more	☐ 0 ☐ 1 ☐ 2 ☐ 3
Lying down in the afternoon	☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting and talking to someone	☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting quietly after lunch (no alcohol)	☐ 0 ☐ 1 ☐ 2 ☐ 3
Stopped for a few minutes in traffic while driving	☐ 0 ☐ 1 ☐ 2 ☐ 3

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

Do you nap? ☐ Y ☐ N

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/day? _____

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

DR. TYSON'S NOTES:

DME: Aerocare Medical Necessities Apria Other: _____ **AHI:** _____ **DL:** _____

PAP helping? _____

Changes to PMHx/SocHx/FmHx since last visit: _____

Assessment: _____

Plan: _____ Schedule: HSAT PSG Split MSLT

Driving Precautions: _____ Sleep Hygiene: _____

SCT: _____ F/U: _____

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