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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