

MidState
PULMONARY

SLEEP CLINIC FOLLOW-UP

DR. JORDAN PHILLIPS

Name: _____ Date: _____

Age: _____ DOB: _____

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

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

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 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

PEACOCK ■ CARPENTER ■ CAPIZZI ■ TYSON ■ PRITCHETT ■ ATWATER ■ PHILLIPS ■ FERRELL

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