

MidState  
PULMONARY

# SLEEP CLINIC NEW PATIENT NOTES

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  M  F Referring Provider: \_\_\_\_\_

Temp: \_\_\_\_\_ BP: \_\_\_\_\_ HR: \_\_\_\_\_ RR: \_\_\_\_\_ O<sub>2</sub> 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**