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

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