

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? \(\sup Y \subseteq N	
Have you been told that you "stop breathing" and make loud snoring, gasping, or choking sounds? \square Y \square 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? \square Y \square N If yes, how many packs/day, for how many years?	
Do you drink caffeinated beverages?	
Do you drink alcohol?	
Do you use any prescription or over the counter sleep medicines?	
For MD use: Reviewed with patient (initial)	
PHYSICIAN NOTES	