

## SLEEP CLINIC NEW PATIENT NOTES

		$\square$ DR.	RICH I	YSON		☐ DR. 、	JORDA	AN PHILLIPS		
Name:										
Age:	DOB:		Gender	: M	F Ref	erring Pro	ovider:			<del> </del>
Temp:	_ BP:		HR:		RR:		0 <sub>2</sub> Sat _	on [] RA	oxygen _	lpm
Weight:										
Thank you for	visiting t	he clinic t	oday. Ple	ase ansv	wer the c	questions	below.	Thank you.		
What time do yo	u usually	get into bed	d?							
How long does it										
How many times	do you ty	pically wak	e up betw	een bedtir	me and g	etting out o	of bed in	the morning?		
What time do yo	u typically	get out of	bed?							
Do you usually for	eel rested	when you	wake up ii	n the morn	ning?					
Do you experien	ce mornin	ig headach	es?							
Do you have tro	uble stayir	ng awake d	uring the	day (exces	ssive day	time sleepi	ness)? _			
EPWORTH SLE 0 = would never 3 = high chance	doze or s	leep. 1 = sli	ight chanc							
Situation Sitting and readi Watching TV Sitting inactive ir Being a passeng Lying down in th Sitting and talkin Sitting quietly aff Stopped for a fer Total score (add	n a public ger in a mo e afternoo ig to some ter lunch ( w minutes	otor vehicle on eone no alcohol) s in traffic w	hile drivin	g		CHAN  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1   1   1   1   1   1	2 3 2 3 2 3 2 3 2 3 2 3	LEEPING	
Do you snore low Have you been to Do you nap? What is your em	old that yo	ou "stop bre f yes, for ho	ow long _	, ho	w often _	, at a	approxin	nately what time	e	?
Do you work shift										
Do you smoke?	$\square$ Y $\square$ N	I If yes, ho	w many p	acks/day		, for hov	v many y	years	?	
Do you drink caf	feinated b	everages?	□ Y □ N	If yes, h	now many	per day?		·		
Do you drink alc	ohol? 🗌 `	Y 🗌 N If y	es, how n	nany drink	s per day	?		<del> </del>		
Do you use any	prescription	on or over t	he counte	r sleep me	edicines?					<del></del>
For MD use: Re	viewed wi	ith patient (	initial)							
				Pŀ	HYSICIAN	NOTES				