SLEEP CLINIC NEW PATIENT NOTES

☐ DR. RICH TYSON ☐ DR. BIJOY JOHN

Name: _____ **Date:** _____

Age: _____ **Gender:** ☐ **M** ☐ **F** **Referring Provider:** _____

Temp: _____ **BP:** _____ **HR:** _____ **RR:** _____ **0_2 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	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 of 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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