

Sleep Intake

Sleep Center Referral, Pulmonary Associates (Template Sx.Sleep.OSA.New, ver 1.1)

OFFICE USE ONLY:

MR#: _____

HPI:

Name: _____ DOB: _____ Date: _____

➤ **Please check if you have ever or ever been told by someone that you:**

- snoring stop breathing choke/gag arousals night time sweating
 dry mouth in AM headache in AM frequent arousals night time urination
 restless legs leg or body jerks leg cramps Other _____
 sleepiness fatigue tiredness memory problems concentration problems
 irritability depression anxiety Other _____

➤ **Have you ever had a sleep study?** No Yes, if so where _____, when _____

➤ **Do you have trouble:** initiating sleep maintaining sleep both neither

➤ **Check any medicines that you take for sleep:**

- Ambien/zolpidem Lunesta Restoril Trazadone Elavil Melatonin
 Doxepin Klonopin OTC sleep aids Other _____

➤ **Please rate your chance of falling asleep in the following situations:**

(Use this scale: 0 = never, 1 = slight chance, 2 = moderate chance, 3 = high chance)

- | | |
|---------------------------------------|--------------------------------------|
| Sitting or reading _____ | Watching TV _____ |
| Sitting inactive in public _____ | Passenger in car for 1 hour _____ |
| Lying down to rest in afternoon _____ | Sitting and talking to someone _____ |
| Sitting quietly after lunch _____ | Driving, stopped in traffic _____ |

Total Score: _____

IMPORTANT: Driving while sleepy is dangerous. Many people have died or killed others after falling asleep while driving. If you are having problems staying awake while driving, please let us know, and **DO NOT DRIVE WHILE SLEEPY.** Please initial after reading: _____

PE:

Gen-

MP- 1 2 3 4

Den- Y N

Neck-

CV- M G

Chest-

Abd-

Ext-

Please check any of the following symptoms which apply to you:

➤ **CONSTITUTIONAL**

- Fever Chills Sweats Weight Gain Weight loss

➤ **HENT**

- Headaches Post nasal drip Nasal Congestion Nasal discharge

➤ **SLEEP**

- Snoring Insomnia Daytime sleepiness