Sleep Medicine Institute of Texas, PA Patient Name: _____ Date of Birth: _____ **MEDICATIONS** Local Pharmacy Name: ______ Phone # _____ Mail Order Pharmacy Name: Are you allergic to any medication? ____ Yes _ No Name the medications you are allergic to: Medication Strength Directions

Date

Reviewed by

Sleep Medicine Institute of Texas, F	P	١
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atient Name:		
I	Date of Birth:	

Date

Epworth Sleepiness Scale (ESS)

This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each

What are the chances of you feeling sleepy in the following situations?	Unlikely 0	Mild 1	Moderate 2	High 3
Likelihood of feeling sleepy while Sitting and reading				
Likelihood of feeling sleepy while watching TV				
Likelihood of feeling sleepy while sitting inactive in public places				
Likelihood of feeling sleepy as a passenger in a car for 1 hour without a break				
Likelihood of feeling sleepy In a car, while stopped for a few minutes in traffic				
Laying down in the afternoon to rest, if circumstances permit				
Likelihood of falling asleep while sitting and talking to someone				
Sitting quietly after lunch with no alcohol intake				

GSS	Sco	or	e						

Ghuge	Fatigue	Score	(GFS)
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	Ulluge	ratigue scoi	e (GF3)		
How many hours in the day	do you feel tired?				
Less than 2 hrs	2-4 hrs	4-6 hrs	6-8 hrs	more than 8 hrs	
What is the intensity of your	fatigue? (0 is Minimu	m to 5 is maximu	m)		
How long have you experien	ced Fatigue?				
Less than a week	1 week – 1 month	1 – 6 mont	hs 6 months	– 1 year more th	nan 1 year
Does your fatigue interfere v	vith your lifestyle?	Yes	No		
Does your fatigue interfere v	vith your work?	Yes	No		
GES Score:	Reviewed l	hv:		Date:	

Sleep Medicine Institute	, PA	Patient Name:						
					Date of Birth:			
PATIENT HEALTH INFORM	ATION							
REASON FOR VISIT (list all	your chie	f co	omplaints here):					
Past Medical History: Chec	k any me	dic	al condition you are or	were tre	ate	ed for in the past:		
Medical Condition	Check		Medical Condition	Chec	:k	Medical Condition	Check	
Coronary artery disease		-	OPD			Pulmonary Fibrosis		
Diabetes		N	/lacular Degeneration			Optical Migraine		
Heart Failure		4	ibromyalgia			Obesity		
Hypertension		_	lypothyroidism			Depression		
Ischemic heart disease			trial Fibrillation			Kidney Failure		
Stroke		-	Glaucoma			ADHD/ADD		
TIA		-	etinopathy			Parkinson's disease		
		1	,					
Past Surgeries	Year	r	Past Tests	Year		Other tests	Year	
			Colonoscopy					
			Endoscopy					
			Mammography		-			
			Bronchoscopy					
			2 D Echo of Heart					
Previous PAP device used:	No	pre	evious PAP use			Previous Mask used		
BIPAP		μ			•	Full face		
CPAP					-	Nasal Pillows		
Auto PAP					-	don't know		
Don't know					_	tried multiple mas	ks	
					-			
Previous Pap machine exp	erience:							
Reviewed by:					ı	Date:		

Sleep Medicine Institute of Texas, PA

atient Name:	
[ate of Birth:

Date: _____

Sleep History and History of Social Habits

Please respond to all the symptoms listed below:

Symptoms:	YES	NO	Do you wake up with:	YES	NO
Choking during sleep			Body sweats		
Decreased work/school productivity			Dry mouth		
Do you work on weekends?			Feeling Alert		
Dreams with anxiety			Feeling Energized		
Enact dreams			Feeling Groggy		
Fall asleep easily			Feeling tired		
Fall asleep with difficulty			Feeling Unrefreshed		
Gasping during sleep			Heart burn		
Hallucinations during sleep			Headache		
Headaches: how long?			Muscle cramps		
Headaches: what time of the day?			Nasal congestion		
Interrupted sleep with bathroom trips			Racing heart rate		
Limbs become restless			Shortness of breath		
Limbs relived by movement/exercise			Sore throat		
Nasal allergy medication use			Wheezing		
Nasal congestion					
Nasal congestion in sleep					
Nasal decongestant use					
Night sweats in sleep			SOCIAL HABITS		
Paralysis during naps			Tea intake per day		
Paralysis while falling asleep			Coffee intake per day		
Paralysis with anger, laughter, excitement			Alcohol intake per day		
Racing heart rate during sleep			Cigars/cigarettes per day		
Sleep in separate bedrooms			Caffeinated soda per day		
Sleep quality: Light, Sound, Variable			Recreational drugs per day		
Snoring disturbs bed partner's sleep			Tobacco use per day		
Snoring: When did it start?					
Snorting during sleep			Previous sleep study:	YEAR	
Stops breathing during sleep			Home sleep study		
Unable to fall asleep			In lab diagnostic sleep study		
Usual estimated sleep time			In lab titration sleep study		
Usual sleep time			In lab split Night sleep study		
Usual wake up time					
Usual Working hours					
Vivid dreams					

Reviewed by:	Date:

Sleep Medicine Institute of Texas, PA

Patient Name:		
[Date of Birth:	

Review of Systems

Date:		
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Blurred vision RHEUMATOLOGICAL ENDOCRINE Eye redness Swollen joints Hypothyroidism Double vision Osteoarthritis Low testosterone EAR, NOSE, THORAT Painful joints Osteoporosis Chronic sinusitis MUSCULOSKELETAL HEMATOLOGICAL Deviated Nasal Septum Amputation of limb Anemia Enlarged tonsils Back pain Bleeding disorder Decreased taste/smell Leg cramps Blood cancers Hearing loss Leg weakness Sickle cell anemia Mouth Breathing Scoliosis Swollen lymph nodes Nose bleeds Swelling of feet Thalassemia Ringing in the ears NEUROLOGICAL IMMUNOLOGICAL Runny nose Brain tumors Immune deficiencies Sore throat Dementia Allergic conditions CARDIOVASCULAR Dizziness GENETIC Seasonal nasal allergies Irritability Congenital renal dise Chest pain Memory loss Congenital heart dise	н снеск	MENTAL HEALTH	CHECK	GASTROINTESTITIONAL	Check	GENERAL
Fatigue Difficulty swallowing Easily irritated General Body aches Gastric reflux Fearful Headaches all day FEMALE GENITOURINARY Frequent crying Headaches in the morning Excessive urination Impaired cognition Increased appetite Endometriosis Insomnia Heading asleep during the day MALE GENITOURINARY Mood changes Weight gain Difficulty with erection Panic attacks Weight gain Difficulty with erection Panic attacks Weight loss Excessive urination at night Suicidal planning EYES Enlarged prostate Suicidal thoughts Headaches migraine Menstrual Irregularities Trouble concentrating Blurred vision RHEUMATOLOGICAL ENDOCRINE Eye redness Swollen joints Hypothyroidism Double vision Osteoarthritis Low testosterone EAR, NOSE, THORAT Painful joints Osteoporosis Chronic sinusitis MUSCULOSKELETAL HEMATOLOGICAL Deviated Nasal Septum Amputation of limb Anemia Enlarged tonsils Back pain Bleeding disorder Bearing loss Leg weakness Sickle cell anemia Mouth Breathing Scoliosis Swollen lymph nodes Mose bleeds Swelling of feet Thalassemia Ringing in the ears NEUROLOGICAL IMMUNOLOGICAL Runny nose Brain tumors Immune deficiencies Sore throat Dementia Allergic conditions CARDIOVASCULAR Dizziness GENETIC Chest pain Memory loss Congenital renal dise Chest pain Memory loss Congenital renal dise Irregular heart beats Numbness of hands/feet Down's syndrome Palpitations Parkinson's disease SKIN RESPIRATORY Seizures /Epilepsy Brittle nails		Claustrophobia		Abdominal pain		Anorexia
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Headaches all day				Difficulty swallowing		Fatigue
Headaches in the morning		· ·		Gastric reflux		General Body aches
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		SKIN		Parkinson's disease		Palpitations
		Brittle nails		Seizures /Epilepsy		RESPIRATORY
		Coarse Hair		· , , , ,		Asthma
Emphysema Tingling sensation in feet OTHER	OTHER			Tingling sensation in feet		Emphysema
Chronic cough Tremors						

Reviewed by:	Date:	