Sleep Services of America
Patient Sleep Evaluation

Patients: Please complete up to page 3.

Patient Name: _____Date of Birth: _____/_____/_____

Medical History
Have you ever been told that you have?

- ❑ High blood pressure
- ❑ Heart attack
- ❑ Atrial Fibrillation or other irregular heart rhythms
- ❑ Congestive heart failure
- ❑ Stroke
- ❑ Heartburn/reflux
- ❑ Diabetes
- ❑ Seizures
- ❑ Lung problems (e.g. asthma, emphysema, COPD)
  Do you use supplemental oxygen? ___
  If yes, at what flow rate? ____ lpm
- ❑ Neurological problems effecting the muscles
- ❑ Mood disorder/psychiatric diagnosis
- ❑ Other medical diagnoses: _____
- ❑ Past surgeries: _____

Dietary information:

Caffeine (coffee, tea, soda): Amount per day (8 oz. container) _____

Alcoholic beverages (beer, wine, liquor): Amount per day (12 oz. container) _____

The Epworth Sleepiness Scale *(patient to complete)*

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 situation.

0 = no chance of dozing 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

Situation	Chance of Dozing (0-3)
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total (10 or greater is abnormal)	

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Sleep Symptoms and History

Please check the box if you answer 'yes' to each question

❑Have you ever been told that you snore?

❑Have you ever been told that you stop breathing or have irregular breathing when you sleep?

❑Are you tired during the day, no matter how much sleep you get?

❑Do you take regular naps?

❑Do you fall asleep in public places?

❑Do you fall asleep at inappropriate times?

❑Do you wake up short of breath or gasping?

❑Do you wake up in the morning with a headache?

❑Do you have a problem falling asleep or staying asleep at night?

❑Have you noticed your concentration or memory to be getting worse?

❑Do you sleep walk or talk in your sleep?

❑Do you jerk your arms or legs during sleep?

❑Have you recently gained weight? If so, how much? _____

❑Have you ever had a car accident related to being sleepy? Do you drive for a living (yes/no)

❑Have you been previously diagnosed with another sleep disorder? If so, what: _____

❑Do you have relatives with sleep disorders? If so, what disorder: _____

Is there anything else you'd like to add about your sleep quality?

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Practitioner Evaluation

Physical Exams
Height: _____(ft/in) Weight: _____(lbs) BP: _____Heart Rate: _____

	Normal	Abnormal	If abnormal, specify by circling or commenting
Head			Retrognathia, cranio-facial deformity
Eyes			
Ears			
Nose			Mucosa inflamed, pale, boggy, polyps, deviated septum
Throat			
Oropharynx			Dry membranes, postnasal drainage,
Cardio exam			Rate, rhythm, blockage, edema, chest pain, S1/S2/S3/S4
Chest/lungs			Wheezes, rales, rhonchi, dyspnea
Neuro exam			Cranial nerves, gait, sensory, motor reflexes, coordination

Assessment and Plan: (If ordering a sleep study, please indicate the suspected diagnosis)

_____
Provider Name (printed)

_____
Provider Signature Date