Sleep Medicine Institute of Texas, PA

Patient Name: _____

Date of Birth: _____

MEDICATIONS

Local Pharmacy Name: _____ Phone # _____

Address: _____ City: _____ State: _____ Zip: _____

Mail Order Pharmacy Name: _____

Are you allergic to any medication? ____ Yes ____No

Name the medications you are allergic to: _____

_____

_____

_____

_____

Medication	Strength	Directions

_____ _____

Reviewed by Date

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Epworth Sleepiness Scale (ESS)

Date_____

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:

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 Score_____

Ghuge Fatigue Score (GFS)

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 Minimum to 5 is maximum) _____

How long have you experienced Fatigue?

☐ Less than a week ☐ 1 week – 1 month ☐ 1 – 6 months ☐ 6 months – 1 year ☐ more than 1 year

Does your fatigue interfere with your lifestyle? _____ Yes _____ No

Does your fatigue interfere with your work? _____Yes _____No

GFS Score: _____ Reviewed by: _____ Date: _____

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PATIENT HEALTH INFORMATION

REASON FOR VISIT (list all your chief complaints here):

_____

_____

_____

_____

Past Medical History: Check any medical condition you are or were treated for in the past:

Medical Condition	Check	Medical Condition	Check	Medical Condition	Check
Coronary artery disease		COPD		Pulmonary Fibrosis	
Diabetes		Macular Degeneration		Optical Migraine	
Heart Failure		Fibromyalgia		Obesity	
Hypertension		Hypothyroidism		Depression	
Ischemic heart disease		Atrial Fibrillation		Kidney Failure	
Stroke		Glaucoma		ADHD/ADD	
TIA		Retinopathy		Parkinson's disease	

Past Surgeries	Year	Past Tests	Year	Other tests	Year
		Colonoscopy			
		Endoscopy			
		Mammography			
		Bronchoscopy			
		2 D Echo of Heart			

Previous PAP device used: ____ No previous PAP use

_____BIPAP

_____CPAP

_____Auto PAP

_____Don't know

Previous Mask used

_____ Full face

_____Nasal Pillows

_____ don't know

_____tried multiple masks

Previous Pap machine experience:

_____

_____

_____

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Sleep History and History of Social Habits

Date: _____

Please respond to all the symptoms listed below:

Symptoms:	YES	NO
Choking during sleep		
Decreased work/school productivity		
Do you work on weekends?		
Dreams with anxiety		
Enact dreams		
Fall asleep easily		
Fall asleep with difficulty		
Gasping during sleep		
Hallucinations during sleep		
Headaches: how long?		
Headaches: what time of the day?		
Interrupted sleep with bathroom trips		
Limbs become restless		
Limbs relived by movement/exercise		
Nasal allergy medication use		
Nasal congestion		
Nasal congestion in sleep		
Nasal decongestant use		
Night sweats in sleep		
Paralysis during naps		
Paralysis while falling asleep		
Paralysis with anger, laughter, excitement		
Racing heart rate during sleep		
Sleep in separate bedrooms		
Sleep quality: Light, Sound, Variable		
Snoring disturbs bed partner's sleep		
Snoring: When did it start?		
Snorting during sleep		
Stops breathing during sleep		
Unable to fall asleep		
Usual estimated sleep time		
Usual sleep time		
Usual wake up time		
Usual Working hours		
Vivid dreams		

Do you wake up with:	YES	NO
Body sweats		
Dry mouth		
Feeling Alert		
Feeling Energized		
Feeling Groggy		
Feeling tired		
Feeling Unrefreshed		
Heart burn		
Headache		
Muscle cramps		
Nasal congestion		
Racing heart rate		
Shortness of breath		
Sore throat		
Wheezing		

SOCIAL HABITS	
Tea intake per day	
Coffee intake per day	
Alcohol intake per day	
Cigars/cigarettes per day	
Caffeinated soda per day	
Recreational drugs per day	
Tobacco use per day	

Previous sleep study:	YEAR
Home sleep study	
In lab diagnostic sleep study	
In lab titration sleep study	
In lab split Night sleep study	

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Review of Systems

Date: _____

GENERAL	Check	GASTROINTESTITIONAL	CHECK	MENTAL HEALTH	CHECK
Anorexia		Abdominal pain		Claustrophobia	
Excessive daytime sleepiness		Colitis		Disorientation	
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	
Falling asleep during the day		**MALE GENITOURINARY**		Mood changes	
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	
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 disease	
Chest pain		Memory loss		Congenital heart disease	
Difficulty breathing lying down		Multiple Sclerosis		Congenital lung disease	
Irregular heart beats		Numbness of hands/feet		Down's syndrome	
Palpitations		Parkinson's disease		**SKIN**	
RESPIRATORY		Seizures /Epilepsy		Brittle nails	
Asthma		Spina bifida		Coarse Hair	
Emphysema		Tingling sensation in feet		**OTHER**	
Chronic cough		Tremors			

Reviewed by: _____ Date: _____