Sleep Clinic New Patient Notes

Name: _____ **Date:** _____

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

BP: _____ **HR:** _____ **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? _____

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 or 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? _____

Do you have any other problems with your sleep? _____

For MD use: Reviewed with patient (initial) _____

PHYSICIAN NOTES

Essential Sleep
CONSULTANTS

Roxanne Valentino, MD
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Patient History

PAST MEDICAL HISTORY ***Do you or have you had any of the following conditions? If yes, please check appropriate box.***

- ☐ Alcohol Abuse
- ☐ Allergy / Hay Fever
- ☐ Anemia / Low Blood Count
- ☐ Arrhythmias (irregular heart beat)
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Problems
- ☐ Cancer-Type _____
- ☐ Cervical Spine Disease / Neck Problems
- ☐ Circulation Problems
- ☐ Colonic Polyps
- ☐ Congestive Heart Failure
- ☐ COVID
- ☐ Diabetes
- ☐ Digestive Problems
- ☐ Drug Use
- ☐ Hormone Abnormalities
- ☐ Emphysema / Lung Disease
- ☐ Epilepsy / Seizures
- ☐ Genital / Urinary Disease
- ☐ Head Injury
- ☐ Headache / Migraine
- ☐ Headache / Tension
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ HIV / Aids
- ☐ Liver Disease / Hepatitis
- ☐ Lumbar Spine Disease / Low Back Pain
- ☐ Menstrual / Sexual Dysfunction
- ☐ Neuromuscular (disease of muscles)
- ☐ Nerve Damage (disease of nerves)
- ☐ Peptic Ulcer Disease
- ☐ Pneumonia
- ☐ Renal / Kidney Disease
- ☐ Shingles
- ☐ Stroke
- ☐ Thyroid Disease

Please list any other conditions for which you have been treated: _____

_____

CURRENT MEDICATIONS ***Please list additional medications on the back of this page.***

Pharmacy: _____

Medication	Dose	Frequency

ALLERGIES TO MEDICATIONS ***Please List Medication And Reaction.***

Medication	Reaction	Medication	Reaction
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

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Patient History

FAMILY HISTORY ***Please Check Appropriate Answer***

MOTHER LIVING? ☐ Yes ☐ No HEALTHY? ☐ Yes ☐ No
FATHER LIVING? ☐ Yes ☐ No HEALTHY? ☐ Yes ☐ No
BROTHERS LIVING? ☐ Yes ☐ No HEALTHY? ☐ Yes ☐ No
SISTERS LIVING? ☐ Yes ☐ No HEALTHY? ☐ Yes ☐ No

List any diseases or Illnesses that run In your family:

_____

_____

_____

SOCIAL HISTORY FOR ADULTS

Are you a smoker? ☐ Yes ☐ No How many packs a day? _____ How long have you smoked? _____

Have you ever smoked? ☐ Yes ☐ No For how long? _____ When did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No How much? _____ How often? _____ Type? _____

Have you used street drugs? ☐ Yes ☐ No If yes, what type? ☐ Marijuana ☐ Heroin ☐ Cocaine ☐ IV Drugs

Do you still use street drugs? ☐ Yes ☐ No If yes, how often? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How far did you go in school? _____ Occupation / Job? _____

SOCIAL HISTORY FOR CHILDREN AND TEENS

Grade in school _____ Name of school _____

Number of Siblings _____ Who lives in your household? _____

PRIOR SURGERIES OR HOSPITALIZATIONS ***Please list surgeries and date***

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

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Review of Systems

Patient Name:_____ **DOB:**____/____/_____ **Date:**____/____/_____

REVIEW OF SYSTEMS: ***Have you recently experienced (Please Check):***

Cardiovascular
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Fluid Accumulation
- ☐ Irregular Heartbeat
- ☐ Shortness of Breath
- ☐ Palpitations

ENT
- ☐ Decreased Hearing
- ☐ Difficulty Swallowing
- ☐ Ringing in Ears
- ☐ Wears Dentures

Gastrointestinal
- ☐ Gastric Reflux/GERD
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Heartburn
- ☐ Blood in Stool

General/Constitutional
- ☐ Chills
- ☐ Cough
- ☐ Cold
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Insomnia
- ☐ Significant Weight Gain
- ☐ Significant Weight Loss

Genitourinary
- ☐ Abdominal Pain
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Painful Urination
- ☐ Urinary Incontinence

Hematology
- ☐ Easy Bruising
- ☐ Recent Transfusion
- ☐ Prolonged Bleeding
- ☐ Anemia

Musculoskeletal
- ☐ Pain in Joints
- ☐ Swollen Joints
- ☐ Weakness
- ☐ Leg Cramps
- ☐ Joint Stiffness
- ☐ Muscle Aches

Neurologic
- ☐ Loss of Use of Extremity
- ☐ Low Back Pain
- ☐ Seizures
- ☐ Tremors
- ☐ Tingling/Numbness
- ☐ Balance Difficulty
- ☐ Gait Abnormality
- ☐ Loss of Strength
- ☐ Neck Pain

Ophthalmology
- ☐ Blurred Vision
- ☐ Wears Glasses
- ☐ Wears Contacts

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal Ideation
- ☐ Claustrophobic
- ☐ Bipolar Disorder
- ☐ Difficulty Sleeping
- ☐ Substance Abuse
- ☐ Suicidal Thoughts
- ☐ Mental or Physical Abuse

Respiratory
- ☐ Cough
- ☐ Pain with Inspiration
- ☐ Shortness of Breath at Rest
- ☐ Shortness of Breath with Exertion
- ☐ Wheezing

Any Medical Conditions not listed? ☐ Yes ☐ No

Please list: _____

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