

**New Patient Visit: Attach patient demo sheet and and copy of insurance card.  
Please fax this completed form to (716) 379-8439**

Last Name	First	MI
Phone	D.O.B.	Sex    M        F
Insurance Co.	Authorization No.	Insurance Phone
Referring Physician		

Nighttime Symptoms	SLEEP HISTORY	Daytime Symptoms
<input type="checkbox"/> Snores during sleep		
<input type="checkbox"/> Stops breathing during sleep ( <i>Apneas observed by partner</i> )		<input type="checkbox"/> Excessive daytime sleepiness: difficulty staying alert during the day, or report of fatigue
<input type="checkbox"/> Choking or gasping sensation		<input type="checkbox"/> Morning headaches
<input type="checkbox"/> Experiences a restless sensation in the legs or arms at bedtime or during sleep		<input type="checkbox"/> Dry mouth, sore throat upon awakening
<input type="checkbox"/> Makes frequent kicking movements during sleep		<input type="checkbox"/> Difficulty focusing and concentrating on tasks
<input type="checkbox"/> Has difficulty falling asleep at the beginning of the night, or difficulty staying asleep		<input type="checkbox"/> Memory impairment
<input type="checkbox"/> Need to urinate at night		
<input type="checkbox"/> Sleepwalking, acting out of dreams or other behavioral episodes during sleep		
<input type="checkbox"/> Other (please describe): _____		

**Medical History:**

Nasal:	<input type="checkbox"/> Allergies	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Deviated Septum	<input type="checkbox"/> Nasal Polyps	<input type="checkbox"/> Congestion
Oral:	<input type="checkbox"/> Large Tongue	<input type="checkbox"/> Large Tonsils	<input type="checkbox"/> Small Pharyngeal Inlet	<input type="checkbox"/> Friedman/mallampati I II III IV	
Resp:	<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema / COPD	<input type="checkbox"/> Dyspnea (SOB)	<input type="checkbox"/> Low Overnight O <sub>2</sub> Saturation	
Cardiac:	<input type="checkbox"/> HTN	<input type="checkbox"/> CAD	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> CHF	<input type="checkbox"/> Edema
GI:	<input type="checkbox"/> Obesity	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> NASH	<input type="checkbox"/> Diabetes	<input type="checkbox"/> GERD
Neuro:	<input type="checkbox"/> Seizures	<input type="checkbox"/> Stroke	<input type="checkbox"/> Cognitive Problem	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Dementia

Exam:    Weight \_\_\_\_\_ lbs.    Height \_\_\_\_\_ inches    Neck Circumference \_\_\_\_\_ inches    BMI \_\_\_\_\_

**Type of Sleep Study:**

Polysomnogram (PSG)     CPAP Titration Study     Split-Night Study     MSLT

Home Sleep Testing (Only tests for breathing disorders: No sleep analysis)     MWT

**Epworth Sleepiness Scale:**

How likely are you to doze off or fall asleep in the situations described below, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to imagine how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze  
1 = slight chance of dozing  
2 = moderate chance of dozing  
3 = high chance of dozing

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (i.e. a movie theater)	0	1	2	3
As a car passenger for more than one hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (without alcohol)	0	1	2	3
In a car, stopped for a few minutes in traffic	0	1	2	3

Score Key: Total Score \_\_\_\_\_  
1-10 Normal Range                      10-12 Borderline                      12-24 Abnormal

Practitioner's Signature \_\_\_\_\_ Date \_\_\_\_\_

Practitioner's Name (print) \_\_\_\_\_ Phone \_\_\_\_\_