(1) **Name:** ____________________ **DOB:** _______ **Appointment date:** __________
Phone: ________________ **Address:** ____________________
CPAP Supply company you current use: ___________
Height: _____ **Weight:** _____
Primary Care Physician: _____

(2) EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

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

Situation	Score
Sitting and reading	0
Watching TV	0
Sitting, inactive in a public place (e.g. theater, meeting)	0
As a passenger in a car for an hour without a break	0
Lying down to rest in the afternoon when circumstances permit	0
Sitting and talking to someone	0
Sitting quietly after a lunch without alcohol	0
In a car, while stopped for a few minutes in traffic	0
Total Score:	
Do you have the urge to move your legs while at rest in the evening?	☐ Yes ☐ No

(3) SOCIAL HISTORY

Recent hospitalization? ☐ No ☐ Yes

If yes, why?

Smoking status: ☐ Never ☐ Current ☐ Past Use

(4) REVIEW OF SYSTEMS

Do you now have or have you had any of the following **since your last visit**? (check all that apply)

General
- ☐ weight change
- ☐ trouble sleeping

Gastrointestinal
- ☐ indigestion/heartburn
- ☐ difficulty swallowing

Genitourinary
- ☐ frequent nighttime urination
- ☐ urinary frequency

Ears/Nose/Throat/Mouth
- ☐ congestion
- ☐ sore throat

Skin
- ☐ skin rash
- ☐ skin changes

Endocrine
- ☐ tired/sluggish
- ☐ night sweats

Respiratory
- ☐ coughing
- ☐ shortness of breath

Psychological
- ☐ anxiety
- ☐ depression

Hematologic/Lymphatic
- ☐ anemia
- ☐ easy bruising

Neurologic
- ☐ headaches
- ☐ memory problems

Cardiovascular
- ☐ chest pain
- ☐ high blood pressure

Allergic/Immunologic
- ☐ seasonal allergies
- ☐ medication allergies

____

OFFICE USE ONLY: Review Med list Update PCP Refills needed?