THE LUNG CENTER

Sleep Disorders Specialists of Manatee

Michael D. Seeman, M.D. • Floyd W. Wells, M.D. • Michael W. Burke, M.D.

Pulmonary, Critical Care and Sleep Disorders Medicine

SLEEP MEDICINE FOLLOW-UP FORM

Today's Date: _____

First Name: _____ **Last Name:** _____

Age: _____ **Phone number:**

Sex: ☐ Male ☐ Female

Current main sleep complaints are :

_____

_____

Please mark all your CURRENT SLEEP DISORDERS/MEDICAL CONDITIONS:

☐ Obstructive sleep apnea
☐ Narcolepsy ☐ Restless leg syndrome ☐ Insomnia

☐ High Blood Pressure
☐ Heart failure
☐ Cardiac Arrhythmia
☐ Asthma
☐ Sinus trouble
☐ Schizophrenia
☐ Diabetes
☐ Chest pains or Angina
☐ Stroke
☐ COPD
☐ Depression
☐ Bipolar disorder
☐ High Cholesterol
☐ Cardiac arrhythmia
☐ Seizure/epilepsy
☐ Anxiety disorder

Please list all other medical problems: _____

_____

Use of CPAP, BiPAP or APAP "If not applicable, please move to the next item"

How many **days per week** you use your device? _____days /week

How many **hours per night**? _____ hr/night

Do you have any problem related to mask or device?

☐ Skin soreness ☐ Skin breakdown ☐ Nasal congestion ☐ Stomach distention
☐ Dry mouth/throat
☐ Mask does not fit well ☐ Air leakage through the mask
☐ Pressure too high
☐ Others _____

Do you use **humidifier**? ☐ Yes ☐ No

Do you use **chin strap**? ☐ Yes ☐ No

Sleep Related History

Please rate yourself by circling the number 1-7 that best describes the degree or frequency that you are bothered by a particular complaint or problem.

1	2	3	4	5	6	7
None	Very slight	Slightly	Moderate	Major	Great	Very great
Never	Rare	Seldom	Occasionally	Often	Very often	Always

Do you still have or How often do you experience the followings?

1 2 3 4 5 6 7 **Loud snoring**
1 2 3 4 5 6 7 **Your bed partner notes that you stop breathing**
1 2 3 4 5 6 7 **Waking yourself up with breakthrough chocking/gasping**

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1 2 3 4 5 6 7 **Feeling unrested** even after adequate hours of sleep?
1 2 3 4 5 6 7 Have you ever **fallen asleep while driving?**

1 2 3 4 5 6 7 **Paralysis (unable to move)** when just falling asleep or waking up
1 2 3 4 5 6 7 **Hallucinations (people, voices, or sounds)** in the room when just falling asleep or when awakening
1 2 3 4 5 6 7 **Sudden muscular weakness** with laughing, angry, or emotional situations
1 2 3 4 5 6 7 **Colorful** or **vivid dreams**

1 2 3 4 5 6 7 **Irresistible urge to move legs** in the evening /night
Circle the type: **aching** **crawling** **creepy** **restlessness**
1 2 3 4 5 6 7 **Legs kicking or twitch during sleep**

1 2 3 4 5 6 7 **Problem falling asleep**
1 2 3 4 5 6 7 **Racing thoughts at bedtime**
1 2 3 4 5 6 7 **Panic attack during sleep**

Have you had **any change in weight over last 6months?**
If yes did you: ☐**Gain** ☐**Lost** **How much?** ____ **lb**
Do you do any exercise? ☐No ☐Yes -> if yes what kind? _____
How often? ____ times per week for ____hours. What time usually? _____am/pm

Epworth Sleepiness Scale:

*In contrast to just feeling tired, **how likely are you to doze off** or fall asleep in the following situations? 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	1	2	3
Never	**Slight chance**	**Moderate chance**	**High chance**

Sitting & reading _____
Watching TV _____
Sitting inactive in a public place (i.e. theatre) _____
As a passenger in a car for an hour without a break _____
Lying down to rest in the afternoon _____
Sitting & talking to someone _____
Sitting quietly after lunch without alcohol _____
In a car, while stopping for a few minutes in traffic _____
Total score: _____

(normal: 1-7, mild: 8-11, moderate: 12-16, severe: 17-20, very severe:21-24)

Sleep Habits:

What time you usually **go to bed?** **Weekdays?**____pm/am **Weekends?**___pm/am
How long does it take for you to **fall asleep?** _____minutes
What time do you usually **get up?** **Weekdays?**_____pm/am **Weekends?**___ _pm/am
How many times do you **wake up** while sleeping? ____times
What is the **reason** usually you **wake up?** ☐Unknown ☐other: _____
Do you take **naps during day?** ☐No ☐ Yes
If yes **how often?** ___times/day. How **many minutes?** _____ min. **What time?** _____

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Social History:

Are you currently smoking? ☐No ☐Yes _____ **packs per day**
Do you drink alcohol? ☐No ☐Yes ___ drink per weeks
Do you use any illicit drug? ☐No ☐Yes->if yes what kind ? _____
Coffee: _____ cups per day. What time is your last drink prior to sleep? ___am/pm
Tea or Ice tea: _____ cups per day. What time is your last drink prior to sleep? ___am/pm
Caffeinated soda: _____ cans per day. What time is your last drink prior to sleep? ___am/pm

Other Medical History & Review of Systems:

Do you have seasonal allergies? ☐No ☐Infrequent ☐ Continuous
Do you have sinusitis? ☐No ☐Infrequent ☐ Continuous
Do you have nasal congestion? ☐No ☐Infrequent ☐ Continuous
Other medical complaints _____

Do you have any **known allergies to any medication?** ☐No ☐ If yes: _____

Recent Surgical History

Type of surgery:

_____

MEDICATIONS:

give list to nurse

STOP! THE REST TO BE FILLED BY THE SLEEP CLINIC STAFF

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