Sleep Medicine and Neurology, PLLC
Dr. Veronica Sesi
Phone (810) 245-6965
Fax (574) 212-0510

Date:_____

Patient Name: _____ Referring Dr:_____

Phone Number: _____ E-Mail:_____

Normal Bedtime: _____ Normal Wake Time: _____

Height: _____ Weight: _____ Neck Size: _____ Minutes to fall asleep: _____

Have you had a prior sleep study? Yes □ No □ If yes: Home Study □ In-lab Study □

Are you using a CPAP machine:_____

Are currently experiencing these symptoms;

Yes □ No □	Daytime Sleepiness/Fatigue	Yes □ No □	Loud/Irregular Snoring
Yes □ No □	Are you currently using oxygen	Yes □ No □	Claustrophobia
Yes □ No □	Unexpectedly Awaken at Night	Yes □ No □	Restless Sleep
Yes □ No □	Headaches upon awakening	Yes □ No □	High Blood Pressure
Yes □ No □	Choking/Gasping in Your Sleep	Yes □ No □	Anxiety or Depression
Yes □ No □	Seizures	Yes □ No □	Sleepwalking or Talking
Yes □ No □	Nightmares or Night Terrors	Yes □ No □	Enuresis (Bedwetting)
Yes □ No □	Taking Opiates/Narcotics	Yes □ No □	Insomnia
Yes □ No □	COPD	Yes □ No □	Shortness of Breath
Yes □ No □	Teeth Grinding	Yes □ No □	Confusional Arousals
Yes □ No □	Do you have Memory Loss	Yes □ No □	Restless Leg Syndrome
Yes □ No □	Witnessed Apnea (stopped breathing)	Yes □ No □	Narcolepsy
Yes □ No □	Dry Mouth upon awakening	Yes □ No □	Sinus problems

ADDITIONAL MEDICAL HISTORY; _____
_____
_____
_____

Family History: □ Hypertension □ Heart Disease □ Sleep Apnea □ Other

Surgical History: _____
_____
_____
_____

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EPWORTH SLEEPINESS SCALE

How likely are you to doze/fall asleep during the following states?

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
While sitting and reading	___
While sitting and watching tv	___
While sitting inactive in a public place (church , doctor's office etc)	___
As a passenger in a car for an hour without a break	___
Lying down to rest in the afternoon when circumstances permit	___
Sitting and talking to someone	___
Sitting quietly after a lunch without alcohol	___
In a car , while stopped for a few minutes in traffic	___

Score _____

MEDICATION LIST

Name: _____ DOB: _____

Allergies: _____

Medication	Dose	Time	Comments