Ear, Nose & Throat & Facial Plastic Surgery Center of Fredericksburg, P.C.

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Patient Name: _____ **Date:** _____

The following are the most common signs and symptoms of sleep apnea. Please check those that apply to you, and explain them below.

_____ Loud, irregular snoring
_____ Snorts, gasps, and other unusual breathing sounds during sleep
_____ Long pauses in breathing during sleep
_____ Excessive daytime sleepiness
_____ Fatigue
_____ Obesity
_____ Impotence
_____ Morning headaches
_____ Bed wetting
_____ Changes in alertness, memory, personality or behavior

_____
_____
_____

Please indicate beside each situation the level that applies to your chance of dozing.

0= No chance of dozing
1= Slight chance of dozing
2= Moderate chance of dozing
3= High chance of dozing

Situation:		Score:
*	Sitting and reading	_____
*	Watching TV	_____
*	Sitting inactive in a public place (Theater or meeting)	_____
*	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	_____

Patient Name_____ Date_____

DOB:_____ Age:_____ Height:_____ Weight:_____ Gender: Male/Female

Sleeping Hours: From_____ to _____ ☐ Night ☐ Day ☐ Evening

Occupation:_____

Chief Complaints:

☐ Snoring	☐ Excessive Daytime Sleepiness	☐ Morning Headaches	☐ Shift Work
☐ Fatigue	☐ Pauses or Stops Breathing during Sleep	☐ Frequent Awakenings	☐ Insomnia
☐ Sleepwalking	☐ Claustrophobia	☐ Sleep Paralysis	

Other:_____

Medications:_____

_____

_____

Allergies:_____

Medical History:

☐ Heart Disease	☐ Diabetes	☐ Arrhythmias	☐ CHF
☐ CVA/TIA	☐ Thyroid Disease	☐ Hypertension	☐ COPD
☐ Asthma	☐ Kidney Disease	☐ Allergic Rhinitis	☐ Depression
☐ Claustrophobia	☐ Anxiety	☐ Recent surgery – list _____	

☐ Other_____

Special Needs & Limitations:

☐ Bathroom ☐ Oxygen _____% or _____LPM ☐ Other_____

Ambulatory Needs:

☐ Walker ☐ Wheelchair ☐ Cane ☐ Other_____

Other Important Information:_____

_____

PHYSICIAN or PATIENT SIGNATURE_____ DATE_____

Insurance Name_____ Pre-Authorization Needed? Yes___ No___

Does patient want called for earlier appointment if there are cancellations? Yes___ No___

Comments_____

DG0920

Mary Washington Healthcare

SDC – Patient Information Sheet

FR-42-MWHC – REV. 1/2010

PATIENT IDENTIFICATION
1 1/4" X 3"