Pulmonary and Sleep Associates of Marin

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SLEEP PATIENT FOLLOW-UP QUESTIONNAIRE

Name: _____ **Date:** _____
Date of Birth: _____

Please list any new medications or changes in your medical history (including diagnoses, hospitalizations, or surgeries) since your last visit:

_____

_____

In the past 2 weeks, have you had any of the following symptoms (Circle if applies):

Weight Change	Confusion	Nasal Congestion	Leg swelling
Loss of Appetite	Memory Problems	Sinus pressure/pain	Heartburn/Reflux
Fevers/Chills/Sweats	Joint/Muscle Pain	Cough	Abdominal Pain
Vision Change	Incoordination/Falls	Shortness of Breath	Nausea/Vomiting
Headaches	Numbness/Tingling	Wheezing	Urinary Problems
Dizziness	Muscle weakness	Chest Pain	Rashes
Tremor	Anxiety/Depression	Palpitations	Other? _____

Epworth Sleepiness Scale:
This scale helps us determine how likely you are to doze off in the following situations. It refers to your usual way of life in recent times. Use the following scale to choose the most appropriate number for **each** situation.

0 – no chance of dozing
1 – slight chance of dozing
2 – moderate chance of dozing
3 – high chance of dozing

SITUATION	**0-3**
Sitting and reading	
Watching TV	
Sitting inactive in a public place (i.e., theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	