

Date: _____

NEW PATIENT SLEEP MEDICINE CONSULT

Patient Name: _____ DOB: _____

PCP Name: _____

PCP Phone Number: _____ PCP Fax Number: _____

Referring Physician: _____

What is your primary sleep problem? _____

Average time asleep nightly (hrs): _____ Average Number of nighttime awakenings: _____

Current Medications (please include dose and frequency):

Drug Allergies: _____

If you have Sleep Apnea:

When were you initially diagnosed? Was your test completed at home or in a facility?

Any other sleep studies completed?

Current form of treatment (CPAP/other device) and Current Pressure Settings (if known):

Type of Mask and supplies details (nasal pillows, nasal mask, full mask):

Current DME company for mask Supplies _____

MEDICAL HISTORY (Please list year diagnosed)

<input type="checkbox"/> No Pertinent Medical History		PSYCHIATRIC HISTORY Please list year diagnosed
<input type="checkbox"/> Obstructive Sleep Apnea	<input type="checkbox"/> Heart Disease/Heart Attack	<input type="checkbox"/> Depressive disorder
<input type="checkbox"/> Central Sleep Apnea/Mixed	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Anxiety disorder
<input type="checkbox"/> Insomnia	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Bipolar disorder
<input type="checkbox"/> Narcolepsy	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Restless Leg Syndrome	<input type="checkbox"/> COPD	<input type="checkbox"/> Attention deficit-hyperactivity disorder
<input type="checkbox"/> Childhood Sleep Terrors or Sleep Walking	<input type="checkbox"/> Asthma	<input type="checkbox"/> Inpatient hospitalization
<input type="checkbox"/> Chronic pain disorder	<input type="checkbox"/> Anemia	<input type="checkbox"/> Alcohol/drug dependence (current)
<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Alcohol/drug dependence (past)
<input type="checkbox"/> Chronic Back Pain	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Other Pertinent Medical History (Please List)
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Parkinson's Disease	
<input type="checkbox"/> Chronic Joint Pain	<input type="checkbox"/> Migraine headache	
<input type="checkbox"/> Hypertension/Blood Pressure	<input type="checkbox"/> Alzheimer's Disease/Other Dementia	
<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> Stroke/TIA	
<input type="checkbox"/> Other cardiac arrhythmias	MALES	
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> BPH/Large prostate	
<input type="checkbox"/> GERD/Heartburn	<input type="checkbox"/> Erectile Dysfunction /Impotence	
<input type="checkbox"/> Diabetes Mellitus	FEMALES	
<input type="checkbox"/> Allergic rhinitis (nasal allergies)	<input type="checkbox"/> Menopause	
<input type="checkbox"/> Seasonal/Environmental Allergies	<input type="checkbox"/> Urinary Incontinence	

SURGICAL HISTORY (Please list year of Surgery)

<input type="checkbox"/> No prior surgeries	<input type="checkbox"/> Orthodontia/Braces	<input type="checkbox"/> Pacemaker/AICD implantation
<input type="checkbox"/> Bariatric Surgery	<input type="checkbox"/> Sinus surgery	<input type="checkbox"/> Neck Surgery
<input type="checkbox"/> ENT Surgeries	<input type="checkbox"/> Surgery for sleep apnea/UPPP	<input type="checkbox"/> Back Surgery
<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Coronary artery bypass	<input type="checkbox"/> Other Pertinent Surgery
<input type="checkbox"/> Deviated nasal septum surgery	<input type="checkbox"/> Cardiac angioplasty/stents	

FAMILY HISTORY Any Family members diagnosed with Sleep Disorder?

FAMILY MEMBER	Sleep Apnea	Narcolepsy	Insomnia	Restless leg Syndrome	Depression	Anxiety	Other Pertinent sleep disorders Please list
Father							
Mother							
Sister							
Brother							
Grandparents							
Children							