National Jewish Health
Science Transforming Life

NATIONAL JEWISH SOUTH DENVER
SLEEP CLINIC FOLLOW UP VISIT INTAKE FORM

Welcome! Please assist us by completing the following form. Remember – always bring in an updated **list of all of your medications**.

Date: _____ **Primary Physician:**_____
Name: _____ **Other Physicians (to send information to):**
Age: _____ _____

Reason for visit: _____

Are you using CPAP/BiPAP for Sleep Apnea? Y N
What company provides your CPAP? _____
What type of mask do you have? Full face mask Nasal mask Nasal pillows
What are your settings? _____
Do you use supplemental oxygen with your CPAP? Y N If so, how much?_____
Do you use a Ramp setting on your CPAP? Y N
Do you use the attached humidifier? Y N
Do you use a chin strap? Y N
How long have you had your current machine? _____**months/years**
How long have you had your current mask? _____**months/years**

How do you feel your mask is fitting? _____
Do you feel the mask is leaking? Y N
Any concerns regarding your CPAP machine or mask?_____
_____

How many hours a night do you wear your CPAP? _____
How many nights a week do you use it? _____
Do you feel rested in the morning after using your CPAP? _____

Check any that apply:
Are you having?

Y N Snoring (Sleeping partner complaining?)
Y N Gasping/choking during the night
Y N Morning headaches
Y N Daytime drowsiness
Y N Drowsiness while driving
Y N Restless legs
Y N Weight gain or loss _____lbs in _____months
Y N Dry mouth after using CPAP
Y N Nasal congestion
Y N Difficulty falling asleep
Y N Difficulty staying asleep

Smoker? Y N # years _____ Avg # packs per day ____ Year quit_____
Alcohol? Y N How much? _____ How often? _____

Any changes in your past medical history since your last visit?
_____
_____
_____

Preferred Retail Pharmacy _____

Address _____

Phone # _____ **Fax #**_____

Preferred Mail Order Pharmacy _____

Address _____

Phone # _____ **Fax #** _____

Preferred Laboratory (circle one) **Quest** **LabCorp** **Any**

Vaccination/Immunization History	**Date of Last Immunization Month / Year**
Flu (Influenza) Shot	/
High Dose Flu Shot	/
Pneumovax (Pneumococcal Pneumonia)	/
Prevnar (Pneumococcal Pneumonia)	/

Epworth Sleepiness Screening

Assess how likely you are to fall asleep or doze off during the following situations:

0 = Would **never** doze
1 = **Slight** chance of dozing
2 = **Moderate** chance of dozing
3 = **High** chance of dozing

Situation	Chance of Dozing (circle one)
1. Sitting or reading	0 1 2 3
2. Watching TV	0 1 2 3
3. Sitting inactive in public	0 1 2 3
4. As a passenger in a car for an hour	0 1 2 3
5. Lying down to rest in the afternoon	0 1 2 3
6. Sitting and talking to someone	0 1 2 3
7. Sitting quietly after lunch without alcohol	0 1 2 3
8. In a car while stopped for a few minutes in traffic	0 1 2 3

Score: