

Matthew L. Finerman, MD

Please Print

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Male: Female:

Height: _____ Weight: _____ Neck Size: _____

PAST OR CURRENT MEDICAL ILLNESSES

Hypertension	Yes	No	Thyroid Disease	Yes	No
Irregular Heart Beat	Yes	No	Asthma	Yes	No
Heart Failure	Yes	No	Sinusitis	Yes	No
Sleep Apnea	Yes	No	Diabetes	Yes	No

Current Medications:

Allergies to Medications: _____

SURGERIES {Please write the date you had the surgery}

Tonsillectomy _____	Adenoidectomy _____
Nasal Surgery _____	Uvulopalatoplasty _____
Sinus Surgery _____	Tracheostomy _____

Do you smoke? No Yes Quantity/Day _____

Do you drink alcohol? No Yes Quantity/Day _____

Do you use sleeping pills? No Yes Quantity/Day _____

Do you exercise? Never Rarely Occasionally Regularly

Have you ever been diagnosed with sleep apnea? Yes No

By whom (physician's name) _____

Based on what kind of test? _____

How loudly do you snore? Mild Moderate Extreme

Does your snoring bother your partner? Mild Moderate Extreme

Have you ever been asked to sleep in another bed or bedroom?	Yes	No
Has your sleep partner ever moved to another room because of your snoring?	Yes	No
Difficulty or frustration with sexual activity?	Yes	No
Difficulty with memory or concentration?	Yes	No
Difficulty breathing during the day? Difficulty breathing during the night? Difficulty breathing through your nose? Mouth breathing at night?	Yes	No
Excessive movements during sleep? Tired all the time? Difficulty staying awake while driving?	Yes	No
Narcolepsy (falling asleep involuntarily during the day?)	Yes	No
Difficulty staying awake during the day?	Yes	No
Suddenly awakening with heart pounding? Do you wake up gasping for air? Do you frequently wake up with a headache? Do you dream nightly?	Yes	No
Any reported periods when you stop breathing at night? "APNEA"	Yes	No

Please indicate the likelihood that you would fall asleep in the following situations. Choose the most appropriate number for each situation.

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = *high* chance of dosing

<u>Situation</u>	<u>Chance of Dozing</u>
Sitting and reading	_____
Watching Television	_____
Sitting, inactive in a public place (e.g. movie)	_____
As a passenger in a car for an hour without break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Signature of person completing form