Neurology & Sleep Associates

Rajiv B. Nanavaty, M.D.
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DeJa Davis, D.N.P
Nancy D. Myers, P.A.

Patient Name: _____ Date of Birth: _____

Referring Physician: _____ Primary Care Physician: _____

MEDICAL HISTORY – SLEEP

Have you ever had your tonsils removed? ☐ Yes ☐ No

Have you ever had your adenoids removed? ☐ Yes ☐ No

Have you had any other surgeries? ☐ Yes ☐ No

If Yes, please list surgery and date (mm/yy): _____

Allergies: _____

Please list all **CURRENT MEDICATIONS** or provide us with a current medication list. We can make a copy for our records. If you need more room, you may use the back of this page. List Medication and how often do you take this medication.

REASON FOR THIS VISIT:

Why are you seeking treatment at this time? (check all that apply)

☐ Snoring
☐ Difficulty falling asleep
☐ Disruptive behaviors during sleep
☐ Excessive daytime sleepiness
☐ Other: _____
☐ Difficulty staying asleep
☐ Leg movements during sleep
☐ Poor sleep-wake schedule

When did your sleep problems start? _____

Have you ever had a sleep evaluation or overnight sleep study (polysomnography)? ☐ Yes ☐ No

If yes, where was study performed? _____

Were you ever diagnosed with apnea? ☐ Yes ☐ No

If Yes, what treatment did you receive? _____

Are you still utilizing the treatment ☐ Yes ☐ No

If No, why not? _____

OFFICE USE ONLY: Height: _____ ft _____ in Current Weight: _____ lbs

Neck circumference _____ BP: _____ Pulse _____

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EPWORTH SLEEPINESS QUESTIONNAIRE:

How likely are you to doze off or fall asleep in the 8 situations described below, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze off
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (eg, a theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
TOTAL:				

SUSPECTED SLEEP APNEA QUESTIONNAIRE:

Are you snoring loudly	☐ Yes	☐ No
Experiencing excessive daytime sleepiness?	☐ Yes	☐ No
Do you stop breathing while you sleep?	☐ Yes	☐ No
Have high blood pressure?	☐ Yes	☐ No
Are you more than 50 years old?	☐ Yes	☐ No

I hereby authorize treatment by the physicians of Neurology and Sleep Associates of Suffolk.

_____ _____

Patient/Guardian Signature Date