

SLEEP DISORDERS CENTER OF VIRGINIA

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PATIENT FOLLOW UP

Patient Name: _____

Currently, how likely are you to fall asleep in the following situations? Please use this scale to estimate.

Situation	would never doze	slight chance of dozing	moderate chance of dozing	high chance of dozing
Sitting and reading	___0	___1	___2	___3
Watching TV	___0	___1	___2	___3
Sitting, inactive in a public place (e.g. in a theater or meeting)	___0	___1	___2	___3
As a car passenger 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 with 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

Have you noticed a difference in your sleep? No Yes (please explain):

Have you noticed a difference in your daytime alertness? No Yes (please explain):

Please list your current medications: None

Please list your current medication allergies: None

Please list your current primary care physician and any other doctors who need copies of today's visit:

Which pharmacy would you like on file?
Pharmacy Name, Address, City, State, Zip: _____
Pharmacy Phone: (_____) _____

Smoking Status: Current every day smoker Never smoker
 Current some day smoker Former smoker

Office Staff - Select PATIENT FOLLOW UP FORM document type

OFFICE USE ONLY:

Patient Name: _____

Date: _____

Weight: _____ lb.

BP: _____

Pulse: _____

SpO2: _____ %

- ___ New Photo Taken
- ___ Pt Refused Photo
- ___ Less than one year since last photo

Initials: _____

Medication Change: _____

Mask: _____

Pressure: _____

Mask Change: _____

Oximetry: _____

Tech Initials: _____

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