BOGAN SLEEP CONSULTANTS

Follow-Up Appointment Patient Medical History and Sleep Questionnaire

Please complete **all questions contained in the following paperwork** so that we may provide you with a comprehensive assessment at the time of your appointment. Failure to complete this information may result in a potential delay in your appointment time.

Date: ___/___/___ Patient Name: _____ Date of Birth: ___/___/___

We send a copy of your office notes and any sleep studies performed to the medical provider who referred you to our office. If you would like for us to send medical records to your other health care providers, please list them below.
Physician Name: _____ Phone Number: _____

EPWORTH SLEEPINESS SCALE

On average over the last month with current treatment:
How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not 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
1 = slight chance of dozing
2 = moderate chance of dozing 3 = high chance of dozing

Situation:	Chance for Dozing
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (ex: theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL SCORE	_____

Health History

Have you had any changes in your health since we last saw you, including a new diagnosis, surgeries, or hospitalizations?
Yes No If yes, please explain: _____
_____ **Allergies**
Are you allergic to any medications? Yes No If yes, please list: _____
_____

Medications

Have you had any medication changes since you were last seen at our office (new, discontinued, or changes in dosages of medications, prescriptions, and over the counter medications, including herbal supplements and inhalers)? Yes No

Please indicate the changes below or you may list all of your medications if you are unsure if there have been changes. In order to decrease the amount of time you are having to wait, if you have a copy of a list of your medications, **please provide this to the receptionist before being called back for your appointment** and disregard the space provided below.

Name	Strength/Dosage	Amount	Times Taken
Example: Ambien	10 mg	1	At bedtime

Your preferred pharmacy: _____
Pharmacy Address: _____
Pharmacy Phone Number: _____

Preventative Care

Have you had a Flu shot this season (ages 50+ only)? Yes No
Have you ever had a Pneumonia vaccine (ages 65+ only)? Yes No
Have you had a colonoscopy in the last 10 years (ages 50-75 only)? Yes No

Recent Sleep History

Average time for "lights out" at home (when you plan to go to sleep): _____ AM/PM
Average time to fall asleep _____ minutes hours
Average number of awakenings per night _____ times
Average time in bed _____ hours per night
Average total sleep time _____ hours per night
Average time for "lights on" at home (when you plan to get up) _____ AM/PM
Does your bedtime vary more than one hour on weekends? Yes No If yes, when? _____
Approximately how many hours a night, on average, are you using your CPAP/BIPAP? _____
Would you say that you feel better as a result of using your CPAP/BIPAP? Yes No
Are you still experiencing daytime sleepiness? Yes No

Thank you for your time and attention in completing this form! To ensure that your appointment is not delayed, please make sure that all of the above information is correct and complete. If you received a Supplemental Sleep Questionnaire, please complete this as well so that we may provide you with the best possible care regarding your sleep and personalized treatment options during the time of this office visit. We appreciate your cooperation and look forward to increasing the quality of your sleep and medical care!

Modified F.O.S.Q

Patient name: _____Date of Birth: _____Date: _____

Please assign each answer a score with the following answers:

1= Yes, Extreme 2= Yes, Moderate 3= Yes, A Little 4=No

QI. Do you have difficulty concentrating on the things you do because you are sleepy or tired? _____

Q2. Do you generally have difficulty remembering things because you are sleepy or tired? _____

Q3. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles)? _____

Q4. Do you have difficulty operating a motor vehicle for long distances (more than 100 miles)? _____

Q5, Do you have difficulty visiting family or friends in their home because you become sleepy or tired? _____

Q6. Has your relationship with family, friends, or work colleagues been affected because you are sleepy or tired? _____

Q7. Do you have difficulty watching a movie or video because you are sleepy or tired? _____

Q8. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired? _____

Q9. Do you have difficulty being as active in the evening as you want to be because you are sleepy or tired? _____

Q 10. Has your mood been affected because you are sleepy or tired? _____

TOTAL: _____

Insomnia Questionnaire

This is a test to assess, in general, how you are feeling about your sleep. Answer the questions rating how you feel about your sleep using a "0-4" point scale—with "0" representing no problem with your sleep and "4" representing a big problem with how you feel about the quality of your sleep.

On Average over the Last Month on Current Treatment:

Circle the answer that best describes your sleep.	No problem with my sleep	Slight problem with my sleep	Moderate problem with my sleep	Moderately severe problem with my sleep	Big problem with my sleep affecting all parts of my life
Overall, describe your satisfaction with your sleep?	**0**	**1**	**2**	**3**	**4**
How easy is it for you to fall asleep?	**0**	**1**	**2**	**3**	**4**
How worried are you that you won't be able to sleep?	**0**	**1**	**2**	**3**	**4**
Are you easily awakened by sounds and noises in the night?	**0**	**1**	**2**	**3**	**4**
When you sleep in a strange place or a bed other than your own, how much trouble do you have trying to fall asleep?	**0**	**1**	**2**	**3**	**4**
Is your sleep disturbed with frequent awakenings?	**0**	**1**	**2**	**3**	**4**
Can you fall back asleep if you awaken during the night?	**0**	**1**	**2**	**3**	**4**
Are you rested the next day after your night's sleep?	**0**	**1**	**2**	**3**	**4**
Do you think you are getting enough hours of sleep each night?	**0**	**1**	**2**	**3**	**4**
How much does the quality of the sleep affect your next day function (fatigue, mood)?	**0**	**1**	**2**	**3**	**4**

TOTAL SCORE (Add the circled numbers together): _____

Fatigue Severity Scale (FSS) of Sleep Disorders

This questionnaire requires you to rate your **level of fatigue** and measures its impact on you. It contains nine statements that rate the **severity of your symptoms**. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the **past week on current treatment** and the extent to which you agree or disagree that the statement applies to you. A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates a strong agreement. It is important that you circle a number 1 to 7 for every question.

During the past week, I have found that:	**Disagree----------Agree**						
My motivation is lower when I am fatigued.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
My exercise brings on my fatigue.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
I am easily fatigued.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Fatigue interferes with my physical functioning.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Fatigue causes frequent problems for me.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
My fatigue prevents sustained physical functioning.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Fatigue interferes with my carrying out certain duties and responsibilities.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Fatigue is among my three most disabling symptoms.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Fatigue interferes with my work, family, or social life.	**1**	**2**	**3**	**4**	**5**	**6**	**7**

TOTAL SCORE (Add the circled numbers together): _____