NEUROLOGY & SLEEP ASSOCIATES OF SUFFOLK

Rajiv B. Nanavaty, M.D. | Shubh Sharma, M.D. | Lacey D. Lyle, FNP

Patient Name: _____ Date of Birth: _____

Referring Physician: _____ Primary Care Physician: _____

MEDICAL HISTORY

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 _____

150 Burnett's Way | Suite 320 | Suffolk, VA 23434 | Phone 757-934-1900 | Fax 757-925-6719

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Patient Name: _____

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

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