SOUND SLEEP HEALTH

FOLLOW UP VISIT FORM

Date:		Date of Birth:
First Name:	**MI:**	**Last Name:**
Address:		City/State/Zip:
Home Phone:	Cell Phone:	Work Phone:
Who are your current HEALTH CARE PROVIDERS? Please list names and phone contacts:		
Please list YOUR MEDICATIONS:		
Any CHANGES IN YOUR LIVING ARRANGEMENT, EMPLOYMENT OR EDUCATION since last visit?		
Any CHANGES TO YOUR DIET OR LEVEL OF ACTIVITY since last visit?		

Please CIRCLE ANY SYMPTOMS below that you have experienced IN THE PAST FEW WEEKS.	
Allergic reaction to a food, medication or other allergen	Swelling in feet, legs or hands, pain in calves with walking
Side effects from medication or supplement	Difficulty swallowing, heartburn, nausea, vomiting
Fever, chills, night sweats, enlarged lymph nodes, fatigue	Significant problems with constipation or diarrhea
Unusual weight gain or weight loss (how much _____)	Blood in stools or black, tarry stools
Skin rash, excessive bruising, mole with changed appearance	Difficulty starting urine stream or emptying bladder fully
Excessive thirst or urination, hair loss, change in skin or nails	Painful urination, bloody or colored urine
Change in sexual drive or performance	Pain or stiffness in back, joints or muscles
Headaches, blurred or double vision, dizziness or vertigo	Unusually high psychological, social or work-related stress
Depressed or anxious mood, trouble with thinking or memory	Diminished hearing, tinnitus, sinus problems, nasal drip
Cough, hoarseness, sore throat, coughing up blood or sputum	Problems falling asleep, staying asleep or waking too early
Drowsiness at home, at work, while driving or operating machinery	Shortness of breath with exertion, wheezing, asthma
Blackouts, loss of consciousness, shakiness or like you might pass out	Snoring, gasping, sleep apnea
Chest pain or pressure, rapid or irregular heart beat	Restless legs sensations; twitching of arms or legs
Trouble or side effects with CPAP, oral appliance or other sleep therapy:	
Any other issues or comments:	

Read the following situations and use the scale provided to rate your sleepiness.
0 = would never doze; 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	
Sitting inactive in a public place (theater, meeting, etc)	0	1	2	3	
Passenger in a car for an hour without a break	0	1	2	3	
Lying down to rest in the afternoon	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after lunch (without alcohol)	0	1	2	3	
In a car, while stopped for a few minutes in traffic	0	1	2	3	
Watching TV	0	1	2	3	Total
Sum:					

Provider Initials: _____ Date: _____