Medical Record Update Form

Name: _____ Date: _____

Have you ever been given a CPAP device? Y ____ N ____

If you have been given a CPAP device, do you use it every night? Y ____ N ____

Are you comfortable with your CPAP and satisfied with its use? Y ____ N ____

If you answered *YES* to all three of these questions, you are done, thank you! If you answered *NO* to any of these questions, please continue to Part 1.

PART 1 : Epworth Sleepiness Scale

How likely are you to doze off while doing the following activities? Please use the following scale: 0= Never, 1= Slight, 2= Moderate, 3= High. Circle one of the following numbers.

Being a passenger in a motor vehicle for an hour or more……	0	1	2	3
Sitting and talking to someone……	0	1	2	3
Sitting and reading……..	0	1	2	3
Watching TV……...	0	1	2	3
Sitting inactive in a public place…….	0	1	2	3
Lying down to rest in the afternoon……	0	1	2	3
Sitting quietly after lunch without alcohol……	0	1	2	3
In a car, while stopped for few minutes in traffic……...	0	1	2	3

PART 2:

Have you ever been told you snore? Y ____ N ____
Do you wake up choking or gasping? Y ____ N ____
Do you have high blood pressure? Y ____ N ____
Do you have diabetes? Y ____ N ____
Have you ever experienced an irregular heart rhythm? Y ____ N ____

PART 3:

Does snoring cause any problems at home? Y ____ N ____
Would you like to fix that? (If yes to above question) Y ____ N ____

PART 4: (By Assistants or Hygienist)

Neck Size_____ (Female >15, Male > 16.5)

Height_____ Weight_____

BMI_____ (>30) Mallampati_____ (Class III & Greater) Scalloped Tongue_____

Patient Signature _____

Doctor Signature _____ Date _____