Welcome to Penn Sleep Medicine Westtown

Today's Date: _____

Your Name: _____ Date of Birth: _____

Referring and/or Primary Care Physician: _____

Please check if you frequently experience any of the following symptoms:

□ chest pain	□ numbness	□ speech problems
□ nasal or sinus congestion	□ involuntary movements	□ headaches
□ shortness of breath	□ dizziness or vertigo	□ double vision
□ heartburn/indigestion	□ loss of vision	□ anxiety
□ sleepiness/fatigue	□ loss of hearing	□ confusion
□ bowel or bladder problems	□ loss of smell or taste	□ hallucinations
□ swelling of hands or feet	□ difficulty swallowing	□ neck/back pain
□ joint or muscle pain	□ weight gain or loss	□ memory problems
□ fainting	□ leg discomfort	□ depression
□ palpitations	□ muscle weakness	

THE EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? (This refers to your usual life in recent times, **in the last month**. 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

	CHANCE OF DOZING			
SITUATION	**0**	**1**	**2**	**3**
Sitting and reading	□	□	□	□
Watching TV	□	□	□	□
Sitting inactive in a public place (i.e. a theater or a meeting)	□	□	□	□
As a passenger in a car for an hour without break	□	□	□	□
Lying down to rest in the afternoon when circumstances permit	□	□	□	□
Sitting and talking to someone	□	□	□	□
Sitting quietly after lunch without alcohol	□	□	□	□
In a car, while stopping for a few minutes in traffic	□	□	□	□

Provider Signature: _____ Date: _____ Time:_____