

SNORE AND SLEEP CENTER

Member American Sleep Disorder Association
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CONSULTATION

Date: ____/____/____

Your Name: _____ DOB: _____ Age: _____ Height: _____ Weight: _____

Primary Physician: _____ Referring Physician: _____

Check if appropriate:

- | | |
|---|--|
| <input type="checkbox"/> Daytime sleepiness | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Daily fatigue or tiredness | <input type="checkbox"/> Morning Headaches |
| <input type="checkbox"/> Nap during the day | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Become drowsy or <input type="checkbox"/> Fall asleep while driving | <input type="checkbox"/> Increased irritability |
| <input type="checkbox"/> Become drowsy or <input type="checkbox"/> Fall asleep at work | <input type="checkbox"/> Memory loss/Difficulty Concentrating |
| <input type="checkbox"/> Become drowsy or <input type="checkbox"/> Fall asleep in meetings | <input type="checkbox"/> Decreased Sex Drive |
| <input type="checkbox"/> Become drowsy or <input type="checkbox"/> Fall asleep in church | <input type="checkbox"/> Weight gain in the past 5 years ____ lbs. |
| <input type="checkbox"/> Become drowsy or <input type="checkbox"/> Fall asleep while talking with people | <input type="checkbox"/> Broken jaw |
| <input type="checkbox"/> Become drowsy or <input type="checkbox"/> Fall asleep while watching television | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Become drowsy or <input type="checkbox"/> Fall asleep while reading | <input type="checkbox"/> Sinus surgery |
| <input type="checkbox"/> Restless sleep | <input type="checkbox"/> Wake up with dry mouth |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Wake up with snort or choking/gasping for breath | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Told that you stop breathing when you sleep | |
| <input type="checkbox"/> History of Narcolepsy | |
| <input type="checkbox"/> Fall asleep despite efforts to stay awake (sleep attacks) | |
| <input type="checkbox"/> When laughing, crying, surprised or angry body feels limp | |
| <input type="checkbox"/> Vivid dream- like images or nightmares upon falling asleep or waking up | |
| <input type="checkbox"/> Unable to move when falling asleep or waking up | |
| <input type="checkbox"/> Legs jerking at night | |
| <input type="checkbox"/> Told that you kick at night | |
| <input type="checkbox"/> Leg discomfort at night | |
| <input type="checkbox"/> Cannot keep legs still at night; have urge to move them | |
| <input type="checkbox"/> Aching or crawling sensation in my legs while in bed | |
| <input type="checkbox"/> Difficulty falling asleep | |
| <input type="checkbox"/> Awake for 15 minutes or more before falling asleep | |
| <input type="checkbox"/> Thoughts race through mind making it difficult to fall asleep | |
| <input type="checkbox"/> Worried about things and unable to relax | |
| <input type="checkbox"/> Wake up during the night and unable to fall back to sleep | |
| <input type="checkbox"/> Wake up earlier in the morning than I prefer | |

What is your occupation? _____ Do you work shifts? _____

What time do you normally go to bed? _____ How long does it take you to fall asleep? _____

What time do you normally get up? _____ On weekends? _____

How many times do you usually awaken at night? _____ Do you awaken tired? _____

Have you worn braces or had oral-facial surgery? _____

Do you currently use oxygen? _____

