Patient Intake Form – FAX: 951-501-3561

Date: ____________________

Patient Name:____ Date of Birth:_______________________

Gender: M / F Home Phone:______________________ Cell:________________ Work:___________

Address:____

City:__________________________________ State:______________________ Zip:__________________

Height:________________ Weight:______________ Neck Size:_____________BMI:________________

Primary Care Physician:________________________________ Phone Number:______________________

Name of Insurance:__________________________________ Member ID #:_______________________

Group #: Insurance Phone #

Have you been Diagnoses with the following?

Obstructive Sleep Apnea: Yes / No

Loud Snoring: Yes / No **High Blood pressure:** Yes / No **Heart disease:** Yes / No **Stroke:** Yes / No

Diabetes: Yes / No **Thyroid:** Yes / No **Insomnia:** Yes/ No **Depression:** Yes / No **COPD:** Yes / No

Morning Headache: Yes / No **Restless Leg Syndrome:** Yes / No **Night time Urination:** Yes / No

Epworth Sleepiness Questionnaire

Use the following scale to choose the most appropriate # for your situation.

0 = Never Doze 1 = Slight Chance 2 = Moderate Chance 3 = High Chance

Sitting and reading	0	1	2	3
Sitting quietly in a public place	0	1	2	3
Watching TV	0	1	2	3
Sitting quietly after lunch w/o alcohol	0	1	2	3
As a passenger in a car not stopping to stretch	0	1	2	3
In a car while stopped in traffic for a few minutes	0	1	2	3
Laying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3

__________ **Total Score***

***If your score is 7 or above, you may be at risk for sleep apnea. Please consult your Doctor.**