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Patient's Name	Date	Clinical Sleep Documentation Guide for Physicians
______________________	________	

	Yes No	**SLEEP APNEA** ( ) Oropharyngeal crowding - small airway – tonsillar hypertrophy ( ) Snoring, choking, gasping, and cessation of breathing for several seconds ( ) Large short neck, unusual jaw position
	Yes No	**MORNING HEADACHES** ( ) Decreased nocturnal oxygen levels ( ) Chronic Fatigue Syndrome ( ) Muscle pain or aggravation of: ( ) fibromyalgia ( ) arthritis
	Yes No	**EXCESSIVE DAYTIME SLEEPINESS (EDS)** ( ) Daytime sleepiness ( ) Decreased energy ( ) Nocturia ( ) Tired after awakening ( ) Fatigue ( ) Restless Leg Syndrome
	Yes No	**OBESITY Weight: ______ Height: ______ BMI: ______** ( ) Weight Gain ( ) Morbid Obesity ( ) Sleep deprivation, fluid retention, and metabolic changes that interfere with weight loss ( ) Neck size greater than > 17 for men, greater than >16 for women
	Yes No	**DIABETES** ( ) Increase in blood glucose levels ( ) Type II Diabetes ( ) Elevated trigylcerides and reduced HDL cholesterol ( ) Linked to metabolic syndrome – weight gain
	Yes No	**DEPRESSION** ( ) Depression and Anxiety resulting in sleep loss and increased cortisol levels ( ) Impotence and decreased sex drive ( ) Nocturnal night sweats
	Yes No	**SAFETY** ( ) Falling asleep while driving, working, at home, or play ( ) Increased risk of accidents ( ) Behavioral Problems ( ) Failing Job Performance
	Yes No	**CARDIAC** ( ) **Other: ______________** ( ) Hypertension ( ) Congestive Heart Failure ( ) Nocturnal Angina ( ) Cardiac Arrhythmias ( ) Myocardial Infarction ( ) Myocardial Ischemia
	Yes No	**NEUROLOGICAL** ( ) **Other: ______________** ( ) Parkinson's Disease ( ) Nocturnal Seizures ( ) Stroke ( ) Narcolepsy ( ) ALS ( ) Parasomnia
	Yes No	**PULMONARY** ( ) **Other: ______________** ( ) COPD ( ) Home Oxygen ( ) Pulmonary Edema
	Yes No	**MEMORY LOSS** ( ) Dementia ( ) Difficulty Concentrating ( ) Alzheimer's Disease ( ) Symptoms interfere with ADLs
	Yes No	**DECREASED MOTOR SKILLS** ( ) Handicapped ( ) Blind or vision impaired ( ) Walker, wheelchair ( ) Deaf or hard of hearing

Physician's Signature ______________________________ **Date** ____________

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