SLEEP MEDICINE ASSOCIATES OF TEXAS, P.A.

PATIENT NAME DOB:

Since your last visit

Has your insurance changed? Yes / No
Has your address changed? Yes / No

Please record change(s):

Please complete the following checklist (as it applies to your condition currently):

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? (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

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting inactive in public place (i.e. theater)	_____
As a car passenger for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopping for a few minutes in traffic	_____

Total Score _____