OGNOMY

FOLLOW UP VISIT

DATE: _____

Name:_____ DOB: _____ Changes to address/phone/insurance? □ No □ Yes

Primary Care Physician: _____ May we send reports to them? □ No □ Yes

Pharmacy & Phone _____ CPAP/BIPAP/Oxygen Supply Company _____

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1. **Since your last visit** have you:
   - seen a physician/health care provider
   - had any changes in your medical history/ medications
   - been hospitalized or undergone surgery
   - had any births, deaths or major illnesses in blood relatives
   - had any changes in your housing, employment, or education
   - had any changes to your use of caffeine, tobacco, or alcohol

   □ No □ Yes - please describe: _____
   _____
   _____

2. Have you experienced any of the items below **recently**?

N	Y	
		awakening at night short of breath
		significant headaches
		cough, shortness of breath, wheezing, asthma
		coughing up blood or sputum
		blackouts or loss of consciousness
		chest pain, pressure, rapid heart beats
		abnormal swelling in the legs or feet
		difficulty swallowing, heart burn, nausea, vomiting
		weight loss or gain of move than 10 lbs over the last six months
		difficulty finding/keeping safe/reliable housing
		difficulty obtaining transportation to work, appointments, or to get food/supplies
		difficulty keeping water, gas or electric service turned on in your home
		physical violence or verbal abuse (threats, insults, cursing) toward you or your children
		Other:

3. Sleep Update:
   Bed Time: _____ Rise Time: _____
   # of Awakenings _____ Hours of Sleep: _____
   Amount of time to fall asleep _____ minutes
   My sleep is □ better □ worse □ about the same

How likely are you to doze off in the situations below:

	High (3)	Moderate (2)	Slight (1)	None (0)
Sitting & reading				
Watching TV				
Sitting inactive in a public place				
Sitting for an hour as a passenger in a car				
Lying down in the afternoon to rest				
Sitting & talking to another person				
Sitting quietly after lunch (no alcohol)				
Sitting in a car stopped in traffic				

Patient Signature:_____ **Date:** _____
