300 B Princeton Hightstown Rd.
E. Windsor NJ 08520 Suite 205
Phone: (609) 490- 1444
Fax: (609) 490 -1133
cmdsleep@live.com

- ☐ Heart Disease
- ☐ Low Blood Pressure
- ☐ Headaches
- ☐ Blackouts
- ☐ Hernia
- ☐ Back Trouble
- ☐ Asthma
- ☐ Cancer
- ☐ Eye Trouble
- ☐ Meningitis
- ☐ Sexual Dysfunction
- ☐ Parkinson’s disease
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Depression
- ☐ Ringing In Ears
- ☐ Fainting
- ☐ Gout
- ☐ Prostate Trouble
- ☐ Allergies
- ☐ Kidney Trouble
- ☐ Hearing Trouble
- ☐ Heartburn
- ☐ Muscle Cramps
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Ulcers
- ☐ Memory Loss
- ☐ Seizures
- ☐ Bronchitis
- ☐ Bladder Trouble
- ☐ Pneumonia
- ☐ Impotence
- ☐ Arthritis
- ☐ Pulmonary Disease
- ☐ Thyroid Trouble
- ☐ AFIB
- ☐ CHF

Height: ______ Weight: _______ Weight gain / loss in the past 2 years: ________lbs.

Blood Pressure_________

List any hospitalizations or surgeries you may have had.____

____

____

EPWORTH SLEEPINESS SCALE TEST YOUR SLEEP
0 = would NEVER doze 1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing 3 = HIGH chance of dozing

- ___ Sitting and reading
- ___ Watching TV
- ___ Sitting, inactive in a public place (in a meeting or watching a movie)
- ___ As a passenger in a car for an hour without a break
- ___ Lying down to rest in the afternoon when circumstances permit
- ___ Sitting and talking to someone
- ___ Sitting quietly after lunch without alcohol
- ___ In a car, while stopped for a few minutes in the traffic

- ___ TOTAL: A score of 8 or higher indicates you may have a sleep disorder

Have you had any previous evaluations, examinations or treatments for this sleep problem or any other sleep problem? Yes_____________ No ___________

If yes briefly describe the results and treatment including medication ____________________________

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Patient Name: ______________________ DOB: _________________ Study Date: ________________