# Medical Update Form

**Name:**_____ **Date:**_____

| | | |
|---|---|---|
| Have you ever been given a CPAP device? | Y____ | N____ |
| If you have been given a CPAP device, do you use it every night? | Y____ | N____ |
| Are you comfortable with your CPAP and satisfied with its use? | Y____ | N____ |

**If you answered *YES* to all three of these questions, you are done, thank you! If you answered *NO* to any of these questions, please continue to Part 1.**

## PART 1: EPWORTH SLEEPINESS SCALE

How likely, are you to doze off while doing the following activities? Please use the following scale: 0= Never, 1= Slight, 2= Moderate, 3= High. Circle one of the following numbers.

| | |
|---|---|
| Being a PASSENGER in a motor vehicle..... | 0 1 2 3 |
| Sitting and talking to someone..... | 0 1 2 3 |
| Sitting and reading ..... | 0 1 2 3 |
| Watching TV..... | 0 1 2 3 |
| Sitting inactive in a public place..... | 0 1 2 3 |
| Lying down to rest in the afternoon..... | 0 1 2 3 |
| Sitting quietly after lunch without alcohol..... | 0 1 2 3 |
| In a car as a DRIVER while stopped for few minutes in traffic..... | 0 1 2 3 |

**TOTAL:** **Score of 8 or more = 1 point.**

## PART 2: Every Yes= 1 point.

| | | |
|---|---|---|
| Have you been told you snore? | ☐ Y | ☐ N |
| If YES, please circle one: **Occasionally OR Every Night** | | |
| Do you ever wake up choking or gasping? | ☐ Y | ☐ N |
| Do you currently have or have had High Blood Pressure? | ☐ Y | ☐ N |
| Do you have diabetes? | ☐ Y | ☐ N |
| Have you been diagnosed with an irregular heart rhythm? | ☐ Y | ☐ N |

## PART 3: Every Yes= 1 point.

| | | |
|---|---|---|
| Does snoring cause any problems at home? | ☐ Y | ☐ N |
| Would you like to fix that? (if yes to above question) | ☐ Y | ☐ N |

**Patient Signature:** _____ **Date:** _____

## PART 4 : By Assistant or Hygienist

Neck Size: _____ **(Excessive Neck size (Female >15, Male >16.5) = 1 point)**

Height _____ Weight _____ BMI _____ **( BMI >30 = 1 point)**

Airway Index(Mallapati) _____ **( Class III or IV Greater = 1 point)**

Scalloped Tongue : YES OR NO **( Scalloped tongue = 1 point)**

**Primary Physician:**_____ **Tel:**_____

**PCP RX _____ OR Schedule Telemedicine Visit_____**

**Total Diagnostic Points:**_____

NOTES:_____