

HOLZER CLINIC, INC.
DIRECT REFERRAL HISTORY AND PHYSICAL FORM
SLEEP EVALUATION

Patient Name: _____ SS#: _____ DOB: _____

Address: _____

Phone: (w) _____ (h) _____ Referring Physician: _____

PHYSICAL CHARACTERISTICS

Height: _____ Weight: _____ Neck Circumference (if known): _____

SLEEP SYMPTOMOLOGY

- The patient states that:
- * Others have witnessed them stop breathing while they are sleeping- YES / NO
 - * They experience headaches upon rising in the morning- YES / NO
 - * They experience excessive daytime sleeping (EDS)- YES / NO
 - * They have been told by others that they snore- YES / NO
 - * They fall asleep at inappropriate times (eating, driving, etc)- YES / NO
 - * They feel weakness when they experience strong emotions-YES / NO
 - * They feel "paralyzed" upon awakening - YES / NO
 - * They experience leg cramps/pain upon rising- YES / NO
 - * They have a crawling sensation in their legs while sleeping- YES / NO

RELEVANT MEDICAL HISTORY

Does this patient have a history of any pulmonary disease (e.g, COPD)?- YES / NO

Comments: _____

Does this patient have a history of cardiac abnormalities (e.g., ASHD, arrhythmia)?- YES / NO

Does this patient have hypertension?- YES / NO

Does this patient have any other medical conditions (e.g., Diabetes, etc.)?: _____

UPPER-AIRWAY ANATOMY

Does this patient have:

- * Any dental abnormalities?- YES / NO Comments: _____
- * A deviated septum or any nasal blockage?- YES / NO Comments: _____
- * Any palate or tongue abnormalities?- YES / NO Comments: _____
- * Microglossia or any other maxillomandibular abnormalities?- YES / NO Comments: _____

MEDICATIONS

Is this patient currently taking any anti-depressant drugs?- YES / NO

If yes, please list what kind: _____

Is this patient currently taking any medication to help them sleep?- YES / NO

If yes, please list what kind: _____

Please list all other current medications: _____

Please list any drug allergies: _____

PLAN: POLYSOMNOGRAM (SLEEP STUDY)

Physician Signature

TO SCHEDULE A SLEEP STUDY

1. Physician or staff must call to schedule study at 1-866-28-SLEEP (75337)
2. Physician must complete, sign, and fax the above form to (740) 446-1298

