





# Sleep Consultation Checklist

Sleep Medicine Centers of WNY will provide medical forms for you to complete as part of your medical records. Use this form to prepare yourself for a consultation:

- ✓ gather information
- ✓ describe symptoms
- ✓ write questions

 = downloadable form

### BUSINESS





- Insurance Card(s) 
- Insurance carrier phone #:   
\_\_\_\_\_
- Appointment date/time:   
\_\_\_\_\_
- Referral
- New Patient Information/ History Form 
- Insurance forms

### HEALTH PROVIDERS

- Primary Doctor:  
name: \_\_\_\_\_  
address: \_\_\_\_\_
- Specialist(s):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### SLEEP PROFILE

### LOGS/QUESTIONNAIRES

- Two week sleep log 
- Sleep questionnaires 
- Epworth Sleepiness Scale 
- Caffeine calculator 

### MEDICATIONS

- Prescriptions:  
drug: \_\_\_\_\_  
dosage: \_\_\_\_\_  
drug: \_\_\_\_\_  
dosage: \_\_\_\_\_  
drug: \_\_\_\_\_  
dosage: \_\_\_\_\_
- OTC drugs/sleeping pills:  
drug: \_\_\_\_\_  
dosage: \_\_\_\_\_
- Herbs/remedies:  
name: \_\_\_\_\_  
dosage: \_\_\_\_\_  
name: \_\_\_\_\_  
dosage: \_\_\_\_\_
- Vitamin/mineral supplements:  
name: \_\_\_\_\_  
dosage: \_\_\_\_\_

### SYMPTOMS

What are my symptoms? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Important sleep-related experiences to share with your sleep specialist: →

- I notice or have been told that I snore, gasp for breath, or stop breathing during sleep.
- I am tired during the day or doze while reading, watching television, or engaging in regular activities.
- I fall asleep or doze off when driving or while at work or school.
- I have difficulty falling or staying asleep.  
Frequency: \_\_\_\_\_
- I often wake up feeling tired/not rested.
- I usually sleep \_\_\_\_\_ hrs. per night.
- I do not keep a regular bed and wake time.
- I often have disruptions to my sleep.  
Cause: \_\_\_\_\_
- I use alcohol and/or smoke.  
Amount/day: \_\_\_\_\_
- I use caffeine products.  
Amount/day: \_\_\_\_\_
- I regularly exercise.  
Time of day: \_\_\_\_\_
- Time of my last meal: \_\_\_\_\_
- I experience nighttime heartburn, pain or the need to urinate.
- I experience significant stress and/or have experienced major lifestyle changes recently.
- I work at night or on rotating shifts.

### GOALS

What do you expect your sleep evaluation to accomplish?

Use the reverse side of this form to write down your questions.

Amherst Sleep  
Medicine Center  
1120 Youngs Road  
Amherst, NY 14221

Buffalo Sleep  
Medicine Center  
3 Gates Circle  
Buffalo, NY 14209

Southtowns Sleep  
Medicine Center  
4090 Seneca St.  
W. Seneca, NY 14224