ZAHIR YOUSAF, M.D., F.C.C.P.

SLEEP DISORDERS CENTER

3995 Old Town Road, Suite 201, Huntingtown, MD 20639
Phone: (410) 535-0666 Fax: (410) 414-2120

Name: _____ Date: _____

DOB: _____/_____/_____ Height: ____'_____" Weight: _____lbs

Social Security Number: _____-_____-_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Referring Doctor: _____

Referring Doctor's Telephone Number: _____

In your own words please write the main reason you are having this test:

_____

Family History: How many Brothers? ____ Sisters? ____

Yes or No? >	Father	Mother	Brother(s)	Sister(s)
Sleep Walking				
Snoring				
Sleep Apnea				
Insomnia				
Narcolepsy				

Medications: ***You are currently taking***

Name	mg	Frequency	Reason you take the medication	Year Started

Allergies to Medications

Medication	Reaction- (rash, swelling, etc.)	Year

On average, how many hours do you sleep at night? _____

How likely are you to doze or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation:

0 = would *never* doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

Situation	**Chance of dozing**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (i.e. a theater or a meeting)	_____
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 a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL	**_____**

*****Please complete this section only if you have been diagnosed with or treated for sleep apnea*****

What year was your sleep apnea diagnosed? _____

What year was you last overnight sleep study? _____

Have you ever had surgery for sleep apnea? Yes / No

If so, what year was your surgery? _____

Please describe the type of surgery that was done:

_____

Have you ever used CPAP therapy? Yes / No

What year was CPAP first prescribed? _____

Do you use CPAP now? Yes / No

How many nights each week? More than 5 / Less than 5

How many hours each week? More than 4 / Less than 4

Please describe any problems you have, or had, with CPAP therapy:

_____

_____

Have you used a dental appliance for sleep apnea? Yes / No

What year was the appliance first prescribed? _____

Do you use the appliance regularly now? Yes / No

Describe any problems you have, or had, with the dental appliance:

_____

_____

MULTIVARIABLE APNEA PREDICTION AND SLEEP SYMPTOM FREQUENCY (MAP) FORM

The following questions refer to your behavior while sleeping, trying to sleep, or while feeling sleepy. Please fill in one circle for each question. During the last month have you had, or have been told about the following?

	Never	Rarely, less than once a week	1-2 times per week	3-4 times per week	5-7 times per week	Don't know
Loud Snoring	○	○	○	○	○	○
Your legs feel jumpy or jerky	○	○	○	○	○	○
Difficulty falling asleep	○	○	○	○	○	○
Frequent awakenings	○	○	○	○	○	○
Snorting or Gasping	○	○	○	○	○	○
Falling asleep while at work	○	○	○	○	○	○
Frequent tossing, turning, or thrasing	○	○	○	○	○	○
Your breathing, stops or you struggle for breath	○	○	○	○	○	○
Any snoring	○	○	○	○	○	○
Excessive sleepiness during the day	○	○	○	○	○	○
Morning Headaches	○	○	○	○	○	○
Falling asleep while driving	○	○	○	○	○	○
Awaken feeling paralyzed, unable to move for short periods	○	○	○	○	○	○
Find yourself in a vivid dreamlike state when falling asleep or awakening although you're awake	○	○	○	○	○	○