MAB
MEDICAL ASSOCIATES OF BREVARD

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Board Certified in Pulmonary & Sleep Medicine.
Critical Care

Patient First & Last name: _____ DOB: ____/____/____

Patient address: _____ City: _____ Zip Code _____

Height: _____ inches Weight: _____ Lbs. BMI: _____

Neck circumference: _____ inches

PATIENT COMPLAINTS (check what applies)

☐ Excessive Daytime Sleepiness ☐ Loud Snoring ☐ Leg Jerks ☐ Other _____

Focused Cardio-Pulmonary Exam

HR: _____

RR: _____

SaO2 : _____

EPWORTH SLEEPINESS SCALE

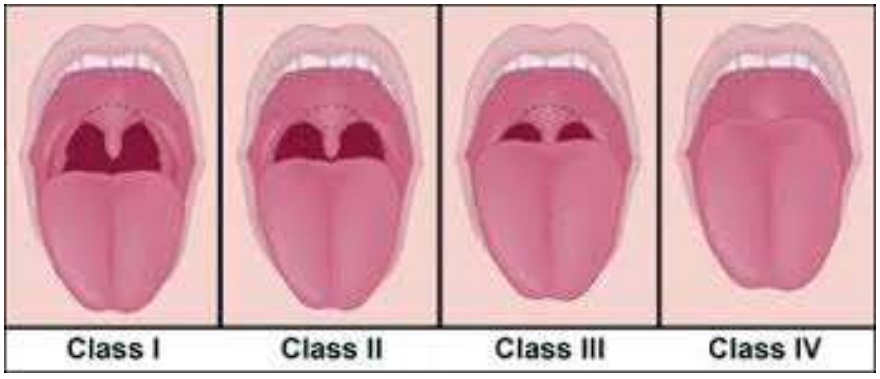
0 = Would never 1 = Slight chance 2 = Moderate chance 3 = High chance

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in the traffic	0	1	2	3

TOTAL

_____
Patient Signature

FOR THE PHYSICIAN (only) - Upper Airway Exam – Mallampatti Score/assessment (Must check one)



DIAGNOSTIC PANEL

_____ 327.23 OSA

_____ 780.53 Hypersomnia with SA

_____ 307.41 Insomnia

_____ 347.00 Narcolepsy

_____ 327.40 Parasomnia

_____ 327.10 Orgnic Hypersomnia

_____ 327.21 Central-Complex SA

_____ 327.51 PLMS

_____ OTHER

This Form completed by: _____ ☐ Physician ☐ MA ☐ PA ☐ NP (please initial)

Dr. Jerry Pinto Signature _____ DATE _____