Please do not affix label

VIOLLIER

Please use a black ballpoint pen, not a pencil.

Patient Record – Pneumology

Concerning the past 4 weeks

☐ Initial examination ☐ Follow-up
☐ Nocturnal polygraphy ☐ Nocturnal pulse oximetry

Last name / First name

Occupation

Date of Birth ☐ ♂ ☐ ♀

1. What medications are you currently taking?

Medication	Dosage	Intake time

2. Do you suffer from any illnesses? If yes, which ones?

Also indicate treated illnesses and previous surgeries.

Please underline:
Mouth, nose, throat, heart, lungs, stomach, intestines, liver, kidney, nervous system, brain, psyche, joints, bones, muscles

Further

3. Questions about daytime sleepiness (Epworth Sleepiness Scale)

0 = would never fall asleep
1 = would almost fall asleep
2 = might fall asleep
3 = would probably fall asleep

How easy would it be for you to fall asleep in the following situations?

Situation				
Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching television	☐ 0	☐ 1	☐ 2	☐ 3
Sitting in public places (e.g. theater, meeting, presentation)	☐ 0	☐ 1	☐ 2	☐ 3
While traveling in a car as a passenger without a break for an hour	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and speaking with someone	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after lunch without having consumed alcohol	☐ 0	☐ 1	☐ 2	☐ 3
In the car, when stopped in traffic for a few minutes	☐ 0	☐ 1	☐ 2	☐ 3
ESS Score (do not fill in)				

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4. Questions about sleep and health in general

Your current weight	kg	Your height	cm
Your weight 5 years ago	kg	Your collar size	cm

	yes	no
Do you smoke?	☐	☐
Do you drink alcohol regularly?	☐	☐
Do you suffer from respiratory arrests at night?	☐	☐
Do you snore?	☐	☐
Has your sleepiness ever caused you to have an accident (work / driving)?	☐	☐
Are you tired during the day?	☐	☐
Do you have concentration problems?	☐	☐
Do you have trouble falling asleep?	☐	☐
Do you have trouble sleeping through the night?	☐	☐
Do you wake up early?	☐	☐
Do you wake up rested in the morning?	☐	☐
Do you have restless movement in your legs, arms when falling asleep or during sleep?	☐	☐
Do you need to urinate at night?	☐	☐
Do you experience any of the following problems?	☐	☐
• Shortness of breath	☐	☐
• Feeling like you are suffocating	☐	☐
• Coughing fits	☐	☐
• Difficulty breathing through your nose	☐	☐
• Anxiety dreams	☐	☐
• Sweating	☐	☐
• Palpitations	☐	☐

5. Recording

Beginning of the recording (date / time)	Bedtime (date / time)
End of the recording (date / time)	Wake-up time (date / time)

Did one or more of the following discomforts occur during the recording?
Please underline: palpitations, shortness of breath, pauses in breathing, coughing

Further

6. State of mind mask therapy

If you already use mask therapy:

	yes	no
Do you still snore and / or do you still have breathing interruptions under the mask?	☐	☐
Do you feel rested in the morning?	☐	☐
Do you find it difficult remaining awake during the day?	☐	☐
Is your nose and / or mouth dry?	☐	☐
Do you have a runny nose?	☐	☐
Do you have a blocked nose?	☐	☐
Do you have flatulences? Do you need to burp?	☐	☐
Does your mask still fit?	☐	☐
Have you ever had to suddenly take off your mask while sleeping?	☐	☐
Do you have pressure sores from the mask?	☐	☐
Does air escape through a leak in the mask (inflamed eyes)?	☐	☐
Do you sweat under the mask?	☐	☐
Do you experience claustrophobia or shortness of breath under the mask?	☐	☐
Do you suffer from a rash from the mask?	☐	☐
Are you or your partner bothered by the noise of the mask?	☐	☐