

# NEUROLOGY AND SLEEP MEDICINE, P.C.

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PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

DATE OF LAST SLEEP STUDY: \_\_\_\_\_

DOB: \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_

What time do you go to bed? \_\_\_\_\_ PM/AM

Days off? \_\_\_\_\_ PM/AM

What time do you wake up & get out of bed? \_\_\_\_\_ PM/AM

Days off? \_\_\_\_\_ PM/AM

How many times do you wake up during the night? \_\_\_\_\_

How many naps do you take per week? \_\_\_\_\_

Are you happy with your quality of sleep? \_\_\_\_\_

If you have a CPAP or BiPAP at home:

How many nights do you use it per week? \_\_\_\_\_

How many hours do you use it while sleeping? \_\_\_\_\_

Is the mask comfortable? \_\_\_\_\_

If not, what is uncomfortable about it? \_\_\_\_\_

If you have been diagnosed with restless legs syndrome:

Are your legs continuing to keep you up while sleeping? \_\_\_\_\_

Do you feel your medication for restless legs is working? \_\_\_\_\_

How much caffeinated coffee do you drink per day? \_\_\_\_\_ oz.

How much caffeinated tea do you drink per day? \_\_\_\_\_ oz.

How much caffeinated soda do you drink per day? \_\_\_\_\_ oz.

How many packs of cigarettes are you smoking per day? \_\_\_\_\_

What medications and vitamins are you taking now:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you having... \_\_\_ Headaches \_\_\_ Chest pain \_\_\_ Shortness of breath \_\_\_ Dizziness

\_\_\_ Stomach problems \_\_\_ Sensory changes \_\_\_ Weight gain \_\_\_ Weight loss

\_\_\_ Muscle pain \_\_\_ Snoring \_\_\_ Awakenings at night

Have you had any changes in your medical health since your last visit? \_\_\_\_\_

Have you had testing performed since your last evaluation? \_\_\_\_\_

Please let us know any medications you need refilled today \_\_\_\_\_

\_\_\_\_\_