Division of Tourin Professional

CONSULTATION REGISTRATION FORM

Name:
Date:

DATE:__________________(mm/dd/yyyy)

FAMILY DOCTOR:

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MEDICAL INFORMATION

PLEASE WRITE OR PREPARE A LIST OF *ALL* CURRENT MEDICATIONS TO BE REVIEWED:

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Do you smoke? YES NO QUIT Year:

Have you had sinus surgery? YES NO

Do you have TB or have you been exposed to TB? YES NO

Do you have any of the following conditions?

Diabetes	Yes	No
Heart or circulatory problems	Yes	No
High blood pressure	Yes	No
Hepatitis	Yes	No
HIV	Yes	No
Clinical depression	Yes	No

Allergies Yes No

list: ______________________________

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Allergies to medications Yes No

list: ______________________________

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Sleepiness Scale

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

(dozing means falling asleep)

CHANCE OF DOZING (0-3)

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