**PHYSICAL EXAMINATION**

<table>
<thead>
<tr>
<th>PATIENT NAME:</th>
<th>DATE</th>
<th>SDI ID #:</th>
</tr>
</thead>
</table>

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<thead>
<tr>
<th><strong>PHYSICAL EXAMINATION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>BP:</td>
</tr>
<tr>
<td>Uvula:</td>
</tr>
</tbody>
</table>

**IMPRESSSION**

**RECOMMENDATIONS**

1. □ NPSG  
2. □ NPSG (Split)  
3. □ Arm Leads  
4. □ Sleep Hygiene  
5. □ Weight Loss  
6. □ Stop Smoking  
7. □ Avoid Alcohol & Sedatives  
8. □ TSH  
9. □ PFT(s)  
10. □ No Driving until diagnosis & treatment is completed.

**PHYSICIAN’S SIGNATURE:**

**DATE:**

**NAME (Print):**

**PART OF THE MEDICAL RECORD**