Your Hospital's Logo Here

SLEEP DISORDERS INSTITUTE

HOSPITAL: DePaul Building Street Address

City, State Zip
Tel: (202) 555 - 1212
Fax: (202) 555 - 1212

PHYSICAL EXAMINATION

PATIENT NAME:	DATE	SDI ID#:	
TATENT NAME.	DATE	351 15 # .	
	CAL EXAMI	NATION	
BP: HR: RR:	WEIGHT:	HEIGHT: BMI:	NECK SIZE:
	Uvula:		
	Soft Palate:		
	Pharynx:		
	Mallampati:		
	Chin		
Class I Class III Class III Class IV	V Nasal Septum:		
HEENT (Others):	<u>'</u>		
, ,			
LUNGS:			
HEART:			
ABDOMEN:			
ABDOWEN.			
EXTREMITIES:			
NEURO:			
	IMPRESSIO	N	
RFO	COMMENDAT	IONS	
1. NPSG 5	Weight Loss	8. 🗌 TSH	
2. NPSG (Split) 6.	Stop Smoking	9 .	
3. Arm Leads 7.	Avoid Alcohol &	10. No Driving unt	l diagnosis &
4. Sleep Hygiene	Sedatives	treatment is co	impietea.
PHYSICIAN'S SIGNATURE:	DATE:	NAME (Print)	
THOUSEN WO GIOTATIONE.	DATE.	(I IIII)	

PART OF THE MEDICAL RECORD