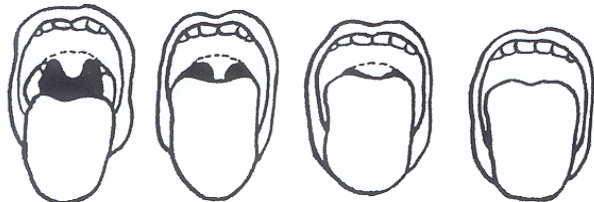


PHYSICAL EXAMINATION

PATIENT NAME:	DATE	SDI ID #:
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PHYSICAL EXAMINATION

BP:	HR:	RR:	WEIGHT:	HEIGHT:	BMI:	NECK SIZE:
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Class I

Class II

Class III

Class IV

Uvula:

Soft Palate:

Pharynx:

Mallampati:

Chin:

Nasal Septum:

HEENT (Others):

LUNGS:

HEART:

ABDOMEN:

EXTREMITIES:

NEURO:

IMPRESSION

RECOMMENDATIONS

- | | | |
|--|---|---|
| 1. <input type="checkbox"/> NPSG | 5. <input type="checkbox"/> Weight Loss | 8. <input type="checkbox"/> TSH |
| 2. <input type="checkbox"/> NPSG (Split) | 6. <input type="checkbox"/> Stop Smoking | 9. <input type="checkbox"/> PFT(s) |
| 3. <input type="checkbox"/> Arm Leads | 7. <input type="checkbox"/> Avoid Alcohol & Sedatives | 10. <input type="checkbox"/> No Driving until diagnosis & treatment is completed. |
| 4. <input type="checkbox"/> Sleep Hygiene | | |

PHYSICIAN'S SIGNATURE:	DATE:	NAME (Print)
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