If prescribed via v-consult®
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VIOLLIER

Patient Record

Polygraphy | Pulse oximetry

Concerning the past 4 weeks

Please use a black ballpoint pen, not a pencil.

Last name / First name

☐ ♂ ☐ ♀

Occupation

Date of Birth

- ☐ Initial examination
- ☐ Follow-up
- ☐ Polygraphy
- ☐ Pulse oximetry

1. What medications are you currently taking?

Medication	Dosage	Intake time

2. Do you suffer from any illnesses? If yes, which ones?

Also indicate treated illnesses and previous surgeries. **Please underline:**
Mouth, nose, throat, heart, lungs, stomach, intestines, liver, kidney, nervous system, brain, psyche, joints, bones, muscles

Further

3. Questions about daytime sleepiness (Epworth Sleepiness Scale)

0 = would never fall asleep 1 = would almost fall asleep 2 = might fall asleep 3 = would probably fall asleep

How easy would it be for you to fall asleep in the following situations?

Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching television	☐ 0	☐ 1	☐ 2	☐ 3
Sitting in public places (e.g. theater, meeting, presentation)	☐ 0	☐ 1	☐ 2	☐ 3
While traveling in a car as a passenger without a break for an hour	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and speaking with someone	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after lunch without having consumed alcohol	☐ 0	☐ 1	☐ 2	☐ 3
In the car, when stopped in traffic for a few minutes	☐ 0	☐ 1	☐ 2	☐ 3

ESS Score (do not fill in)

03.2026 / 18204

4. Questions about sleep and health in general

Your current weight	Your weight 5 years ago	Your height	Your collar size
_____ kg	_____ kg	_____ cm	_____ cm

	yes	no
Do you smoke?	☐	☐
Do you drink alcohol regularly?	☐	☐
Do you suffer from respiratory arrests at night?	☐	☐
Do you snore?	☐	☐
Has your sleepiness ever caused you to have an accident (work / driving)?	☐	☐
Are you tired during the day?	☐	☐
Do you have concentration problems?	☐	☐
Do you have trouble falling asleep?	☐	☐
Do you have trouble sleeping through the night?	☐	☐
Do you wake up early?	☐	☐
Do you wake up rested in the morning?	☐	☐
Do you have restless movement in your legs, arms when falling asleep or during sleep?	☐	☐
Do you need to urinate at night?	☐	☐
Do you experience any of the following problems?	☐	☐
• Shortness of breath	☐	☐
• Feeling like you are suffocating	☐	☐
• Coughing fits	☐	☐
• Difficulty breathing through your nose	☐	☐
• Anxiety dreams	☐	☐
• Sweating	☐	☐
• Palpitations	☐	☐

5. Recording

Beginning of the recording (date / time) _____

Bedtime (date / time) _____

End of the recording (date / time) _____

Wake-up time (date / time) _____

Did one or more of the following discomforts occur during the recording? **Please underline:**
palpitations, shortness of breath, pauses in breathing, coughing

Further _____

6. State of mind mask therapy (if you already use mask therapy):

	yes	no
Do you still snore and / or do you still have breathing interruptions under the mask?	☐	☐
Do you feel rested in the morning?	☐	☐
Do you find it difficult remaining awake during the day?	☐	☐
Is your nose and / or mouth dry?	☐	☐
Do you have a runny nose?	☐	☐
Do you have a blocked nose?	☐	☐
Do you have flatulences? Do you need to burp?	☐	☐
Does your mask still fit?	☐	☐
Have you ever had to suddenly take off your mask while sleeping?	☐	☐
Do you have pressure sores from the mask?	☐	☐
Does air escape through a leak in the mask (inflamed eyes)?	☐	☐
Do you sweat under the mask?	☐	☐
Do you experience claustrophobia or shortness of breath under the mask?	☐	☐
Do you suffer from a rash from the mask?	☐	☐
Are you or your partner bothered by the noise of the mask?	☐	☐