

PLEASE FILL OUT IF YOU ARE AGE 18 OR OLDER.

Patient's Name (PRINT)

| Page 1 | | |
|---|--------------|-------------|
| Section 1: Epworth Sleepiness Scale Please indicate how likely you are to doze off or fall asleep in the following | situations: | |
| Chance of dozing: 0=never, 1=slight PLEASE CIRCLE ONE RESPONSE FOR EACH QUESTION | , 2=modera | ate, 3=hig |
| Sitting and reading | 2 | 3 3 3 |
| As a passenger in a car for one hour | | 3 |
| Driving a car, stopped for a few minutes in traffic 0 1 | | 3 |
| Sitting and talking to someone | | 3 |
| Sitting down quietly, after lunch without alcohol | | 3 3 |
| Section 2: Patient Evaluation | | |
| Fill in the blanks, and circle one yes or no response for each question: | No(0) | Yes(1) |
| BMI (See Attached Chart): Neck Circumference: Is it greater than or equal to 30? Is it >17" (Men) or >15"(Women)? | 0 | 1 |
| Have you gained at least 15lbs in the past 6 months? | ? 0 0 | 1 1 |
| Total Score: | | |
| Section 3: Subjective Sleep Evaluation | | |
| Please circle one yes or no response to each question: | No(0) | Yes(1) |
| Have you been told that you snore? | 0 | 1 |
| You, or your spouse, would consider your snoring louder than a person talk | | 1 |
| Does your snoring occur almost every night? | | 1 1 |
| Is your snoring is bothersome to your bed partner? Do you feel that in some way your sleep is not refreshing or restful? | | 1 |
| Do you often wake up in the middle of the night in order to urinate? | | 1 |
| Do you tend to take a long time to fall asleep at night? | | 1 |
| Do you often wake up and have a difficult time falling asleep again? | | 1 |
| Do you wake up at night or in the mornings with headaches? | | 1 |
| Do you experience fatigue during the day and have difficulty staying awake | | 1 |
| Do you have trouble remembering things or paying attention during the day | <i>ı</i> ? 0 | 1 |
| Do you have high blood pressure? | 0 | 1 |
| Total Score: | | |
| Section 4: Prior Diagnosis | No(0) | Yes(1) |
| Have you ever had a sleep study? | 0 | 1 |
| Have you previously been diagnosed with sleep apnea? If Yes: | 0 | 1 |
| When were you diagnosed? (Approx. mo/yr)/ Were you put on CPAP Therapy for treatment? | | |
| Are you still wearing your CPAP every night? | | |
| Patient's Signature: |)ate:/ | / |
| | | |
| OFFICE USE ONLY: STAFF INITIALS DOCTOR INITIALS | | |