SLEEP DISORDER SYMPTOMS ASSESSMENT

NAME:_____

DATE OF BIRTH: (M/D/YY)____/_____/_____

FOR OFFICE USE:
Height: _____
Weight: _____
BMI: _____
Neck: _____
Blood Pressure: _____

PLEASE CHECK ANY OF THE FOLLOWING YOU MAY HAVE:			
High Blood Pressure___	Heart Disease___	Stroke___	Insomnia___
Frequent Urination At Night (Nocturia)__	Diabetes___	Depression___	Overweight___

SNORING:				SCORE
1. Do you snore often (3 or more nights a week)?	___YES	___NO	___DON'T KNOW	__YES=1
2. Is your snoring loud enough to be heard through a closed door Or annoy other people?	___YES	___NO	___DON'T KNOW	__YES=1
3. Have you noticed or been told that during sleep, you frequently Stop breathing or gasp for air?	___YES	___NO	___DON'T KNOW	__YES=2
			(sum of all numbers checked above) Total Score	

EPWORTH SLEEPINESS SCALE: DOZE OFF	NEVER WOULD	SLIGHT CHANCE	MODERATE CHANCE	HIGH CHANCE
1. Do you get sleepy, or doze off, while sitting and reading?	o 0	o 1	o 2	o 3
2. Do you get sleepy, or doze off, while watching tv?	o 0	o 1	o 2	o 3
3. While sitting or inactive in a public place(meeting/theater)?	o 0	o 1	o 2	o 3
4. As a passanger in a car for an hour without a break?	o 0	o 1	o 2	o 3
5. Lying down to rest in the afternoon?	o 0	o 1	o 2	o 3
6. Sitting and talking to someone?	o 0	o 1	o 2	o 3
7. Sitting quietly after lunch without alcohol?	o 0	o 1	o 2	o 3
8. In a car, while stopped for a few minutes at a traffic light?	o 0	o 1	o 2	o 3

CPAP:
ARE YOU CURRENTLY USING A CPAP? _____YES _____NO IF YES,FOR HOW LONG?_____