

Sleep Disorder Symptoms Assessment

Date _____

Name: _____

Date of Birth: (M/D/Y) ____/____/____ Gender: M____ F____

Insurance Plan: _____

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

Please check any of the following you may have:			
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Frequent Urination at Night (Nocturia)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Depression	<input type="checkbox"/> Overweight

Snoring:	Score
1. Do you snore often (3 or more nights a week)? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Don't Know	___ Yes = 1
2. Is your snoring loud enough to be heard through a closed door or annoy other people? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Don't Know	___ Yes = 1
3. Have you noticed or been told that during sleep, you frequently stop breathing or gasp for air? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Don't Know	___ Yes = 2
(sum of all numbers checked above) Total Score	

Epworth Sleepiness Scale:	Never would doze off	Slight Chance of dozing	Moderate Chance of dozing	High Chance of dozing
1. Do you get sleepy, or doze off, while sitting and reading?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Do you get sleepy, or doze off, while watching TV?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. While sitting or inactive in a public place (meeting, theater)?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. As a passenger in a car for an hour without a break?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. Lying down to rest in the afternoon?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. Sitting and talking to someone?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. Sitting quietly after lunch without alcohol?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8. In a car, while stopped for a few minutes at a traffic light?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(sum of all numbers checked above) Total Score				

CPAP:	
Are you currently using CPAP?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, for how long? _____