

Sleep Evaluation Form

Patient Name: _____

Last

First

MI

Height: _____

Weight: _____

Our office screens for Obstructive Sleep Apnea (OSA). Please respond to the following questions:

Please check any of the following you may have:

- | | | | |
|--|--|--------------------------------------|---|
| <input type="checkbox"/> Morning Headaches | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Frequent Urination at Night | <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Overweight | <input type="checkbox"/> Heart Failure |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Renal Failure | <input type="checkbox"/> COPD | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Grinding Teeth (Bruxism) | <input type="checkbox"/> Restless Legs (RLS) | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Low Testosterone |

Please check Yes or No to the following questions:

- Do you snore or have been told that you snore?** Yes No
- Do you often feel tired, fatigued, or sleepy during the daytime?** Yes No
- Has anyone observed you stop breathing or gasp for air during your sleep?** Yes No
- Do you have or are you being treated for high blood pressure?** Yes No

If you answered Yes to 2 or more of the previous questions, please continue:

Do you get sleepy, or doze off, while sitting and reading?

- 0 Never doze off 1 Slight chance of dozing 2 Moderate chance of dozing 3 High chance of dozing

Do you get sleepy, or doze off, while watching TV?

- 0 Never doze off 1 Slight chance of dozing 2 Moderate chance of dozing 3 High chance of dozing

While sitting or inactive in a public place?

- 0 Never doze off 1 Slight chance of dozing 2 Moderate chance of dozing 3 High chance of dozing

As a passenger in a car for an hour without a break?

- 0 Never doze off 1 Slight chance of dozing 2 Moderate chance of dozing 3 High chance of dozing

Lying down to rest in the afternoon?

- 0 Never doze off 1 Slight chance of dozing 2 Moderate chance of dozing 3 High chance of dozing

Sitting and talking to someone?

- 0 Never doze off 1 Slight chance of dozing 2 Moderate chance of dozing 3 High chance of dozing

Sitting quietly after lunch without alcohol?

- 0 Never doze off 1 Slight chance of dozing 2 Moderate chance of dozing 3 High chance of dozing

In a car, while stopped for a few minutes at a traffic light?

- 0 Never doze off 1 Slight chance of dozing 2 Moderate chance of dozing 3 High chance of dozing

Have you ever been diagnosed with Sleep Apnea? Yes No

Are you currently using CPAP (or any other apnea / snoring device)? Yes No

Are you currently taking any sleeping aids (prescribed or OTC)? Yes No

Are you currently taking any prescribed pain medication? Yes No

FOR OFFICE USE ONLY:

Total Epworth Sleepiness Score: _____