Patient Name (PRINT) _____

Section 1 : Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations:

(0 = never, 1 = slight, 2 = moderate, 3 = high chance of dozing)–CIRCLE ONE RESPONSE FOR EACH QUESTION

Sitting and reading ……	0	1	2	3
Watching television……..	0	1	2	3
Sitting in a public place……	0	1	2	3
As a passenger in a car for one hour……	0	1	2	3
Driving a car stopped for a few minutes in traffic……	0	1	2	3
Sitting & talking to someone……	0	1	2	3
Sitting down quietly after lunch without alcohol……	0	1	2	3
Lying down to rest in the afternoon……	0	1	2	3

Total Score:_____

Section 2 : Patient Evaluation

Fill in the blanks, circle one yes or no response for each question

HEIGHT: WEIGHT: No (0) Yes (1)

BMI (See Bottom Chart):	_____ is it greater than or equal to 30?	0	1
Neck Circumference	_____ _____ is it > 17" (Men) or >15" (Women)	0	1
Have you gained at least 15 pounds in the last 6 months?		0	1

Total Score: _____

Section 3: Subjective Sleep Evaluation

Please Circle one yes or no response for each question	No (0)	Yes (1)
Do you snore?.....	0	1
You, or your spouse, would consider your snoring louder than a person talking…….....	0	1
Your snoring occurs almost every night…….....	0	1
Your snoring is bothersome to your bed partner…….....	0	1
Do you feel that in some way your sleep is not refreshing or restful?.....	0	1
Do you wake up at night or in the mornings with headaches?.....	0	1
Do you experience fatigue during the day and have difficulty staying awake?…..……	0	1
Do you have trouble remembering things or paying attention during the day?.....	0	1
Do you have high blood pressure?.....	0	1

Total Score:_____

Section 4: Prior Diagnosis

	No (0)	Yes (1)
Have you previously been diagnosed with sleep apnea?	0	1

If yes:

When were you diagnosed? (Approximate month/year) _____

Were you put on CPAP Therapy for treatment? _____

Are you still using your CPAP every night? _____

Total Score: _____

Notes: (Please insert any notes for the doctor regarding snoring, sleep patterns or sleep apnea that you feel may be appropriate, use back of page if necessary.)

Patient Signature:_____ Date: _____/_____/_____

OFFICE USE ONLY

Advanced screening criteria, if yes to any below pt should be scheduled for advanced OSA screening.

_____ESS Score ≥ 8? _____Pt. Eval≥2? _____Subjective sleep eval≥ 3? _____Prior OSA Diagnosis≥1?

$$BMI = \frac{703 \times \text{Weight (lb)}}{(\text{Height in inches})^2}$$