Name:_____ Date: _____

Have you ever been given a CPAP device?	Y _____	N
If you have been given a CPAP device, do you use it every night?	Y _____	N
Are you comfortable with your CPAP and satisfied with its use?	Y _____	N

If you answered *YES* to all three of these questions, you are done, thank you! If you answered *NO* to any of these questions, please continue to Part 1

PART 1 : Epworth Sleepiness Scale

How likely, are you to doze off while doing the following activities? Please use the following scale: 0= Never, 1= Slight, 2= Moderate, 3= High. Circle one of the following numbers.

Being a passenger in a motor vehicle for an hour or more	0 1 2 3
Sitting and talking to someone.....	0 1 2 3
Sitting and reading.....	0 1 2 3
Watching TV.....	0 1 2 3
Sitting inactive in a public place.....	0 1 2 3
Lying down to rest in the afternoon.....	0 1 2 3
Sitting quietly after lunch without alcohol.....	0 1 2 3
In a car, while stopped for few minutes in traffic.....	0 1 2 3

Total: **Score of 8 or more = 1 diagnostic point.**

PART 2: Every Yes = 1 diagnostic point.

Have you ever been told you snore?	☐ Y	☐ N
Do you wake up choking or gasping?	☐ Y	☐ N
Have you had high blood pressure?	☐ Y	☐ N
Do you have diabetes?	☐ Y	☐ N
Have you ever experienced an irregular heart rhythm?	☐ Y	☐ N

PART 3: Every Yes = 1 diagnostic point.

Does snoring cause any problems at home?	☐ Y	☐ N
Would you like to fix that? (If yes to above question)	☐ Y	☐ N

Signature _____ Date _____

PART 4: (By Assistants or Hygienist)

Neck Size_____**(Excessive Neck of size (Female >15, Male > 16.5) = 1 diagnostic point)**

Height_____Weight_____BMI_____**(BMI > 30 = 1 diagnostic Point)**

Mallampati_____**(Class III or IV Greater = 1 diagnostic point)**

Scalloped Tongue_____(Scalloped tongue = 1 diagnostic point)_____Schedule telemedicine Visit