Sleep Care Clinic

SLEEP MEDICINE QUESTIONNAIRE

Patient Name: _____ DOB: _____ Date: _____

EPWORTH SLEEPINESS SCALE (ESS)

How likely are you to doze off (not just feel tired) in these situations?

0 = Never 1 = Slight 2 = Moderate 3 = High

1. Sitting and reading _____
2. Watching television _____
3. Sitting inactive in a public place _____
4. Passenger in a car for 1 hour without a break _____
5. Lying down to rest in the afternoon _____
6. Sitting and talking to someone _____
7. Sitting quietly after lunch without alcohol _____
8. In a car, stopped briefly in traffic _____

ESS TOTAL: _____ / 24

Patient Signature: _____ Date: _____

STOP-BANG QUESTIONNAIRE

Check Yes or No for each question.

QUESTION	YES	NO
S – Do you snore loudly?	☐	☐
T – Often tired, fatigued, or sleepy during the day?	☐	☐
O – Has anyone observed you stop breathing in sleep?	☐	☐
P – High blood pressure or taking medication for it?	☐	☐
B – BMI greater than 35 kg/m^2?	☐	☐
A – Older than 50 years?	☐	☐
N – Neck circumference greater than 40 cm (16 in)?	☐	☐
G – Sex assigned at birth male?	☐	☐

STOP-BANG TOTAL: _____ / 8