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:

☐ High Blood Pressure	☐ Heart Disease	☐ Stroke	☐ Insomnia
☐ Frequent Urination at Night (Nocturia)	☐ Diabetes	☐ Depression	☐ Overweight

Snoring:				Score
1. Do you snore often (3 or more nights a week)?	☐ YES	☐ NO	☐ Don't Know	____ Yes = 1
2. Is your snoring loud enough to be heard through a closed door or annoy other people?	☐ YES	☐ NO	☐ Don't Know	____ Yes = 1
3. Have you noticed or been told that during sleep, you frequently stop breathing or gasp for air?	☐ YES	☐ NO	☐ 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☐	1☐	2☐	3☐
2. Do you get sleepy, or doze off, while watching TV?	0☐	1☐	2☐	3☐
3. While sitting or inactive in a public place (meeting, theater)?	0☐	1☐	2☐	3☐
4. As a passenger in a car for an hour without a break?	0☐	1☐	2☐	3☐
5. Lying down to rest in the afternoon?	0☐	1☐	2☐	3☐
6. Sitting and talking to someone?	0☐	1☐	2☐	3☐
7. Sitting quietly after lunch without alcohol?	0☐	1☐	2☐	3☐
8. In a car, while stopped for a few minutes at a traffic light?	0☐	1☐	2☐	3☐
			(sum of all numbers checked above) Total Score	

CPAP:

Are you currently using CPAP? ☐ YES ☐ NO ☐ If yes, for how long? __________

Phone Number: 1-877-753-3776