SLEEP APNEA QUESTIONAIRE

FIRST NAME	M.I.	LAST NAME

DATE OF BIRTH			HEIGHT		WEIGHT	GENDER	
MONTH	DAY	YEAR	FEET	INCHES	LBS.	MALE	FEMALE

Have you been diagnosed or treated for any of the following conditions?

	YES	NO		YES	NO
HIGH BLOOD PRESSURE			STROKE/HEART ATTACK		
DIABETES			DEPRESSION		
HEART DISEASE			SLEEP APNEA		
IRREGULAR HEART BEAT			GERD/ACID REFLUX		

FREQUENCY OF SNORING & SLEEP DISTURBANCES

For each question below, select one of the following responses.

0 = NEVER **1** = RARELY **2** = SOMETIMES **3** = FREQUENTLY **4** = ALWAYS

In the last 6 months, how often have you snored or been told that you snore?									
0		1		2		3		4	

In the last 6 months, have you awaken choking or gasping for air, or been told that you did?									
0		1		2		3		4	

In the last 6 months, have you been told that you stopped breathing while you were sleeping?									
0		1		2		3		4	

EPWORTH SLEEPINESS SCALE

Indicate how likely you are to doze off or fall asleep in the following situations.

0 = Would Never Doze Off **1** = Slight Chance of Dozing **2** = Moderate Chance of Dozing **3** = High Chance of Dozing

	0	1	2	3
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (*park, meeting, theater, etc.*)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking with someone				
Sitting quietly after lunch (*without alcohol*)				
In a car, while stopped for a few minutes in traffic				

PATIENT SIGNATURE	DATE	SLEEP APNEA RISK LEVEL	