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: _____
Mallampati Score: _____

Please check any of the following you may have:			
□ Frequent Urination	□ 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: "Do you get sleepy, or doze off..?"	**Never** would doze off	**Slight Chance** of dozing	**Moderate Chance** of dozing	**High Chance** of dozing
1. While sitting and reading?	0 ☐	1 ☐	2 ☐	3 ☐
2. While watching television?	0 ☐	1 ☐	2 ☐	3 ☐
3. While sitting or inactive in a public place (meeting, theatre)?	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? _____