Sleep Disorder Center

Sleep Disorder Questionnaire and Epworth Sleepiness Scale

Name:_____ D.O.B: _____ Gender: ( ) MALE ( ) FEMALE

Height: _____ Weight: _____ BMI: _____ Neck Size: _____ Doctor:_____

1.	Have you been told that you stop breathing while asleep? (Y) (N)	**Score 8**
2.	Do you awaken suddenly with shortness of breath, gasping or with your heart racing? (Y) (N)	**Score 6**
3.	Have you ever fallen asleep or nodded off while driving? (Y) (N)	**Score 6**
4.	Do you feel excessively sleepy during the day? (Y) (N)	**Score 6**
5.	Has anyone ever told you that you snore while you are sleeping? (Y) (N)	**Score 4**
6.	Have you had weight gain and found it difficult to lose? (Y) (N)	**Score 4**
7.	Have you taken medication for or been diagnosed with high blood pressure? (Y) (N)	**Score 2**
8.	Do you kick or jerk your legs while sleeping? (Y) (N)	**Score 2**
9.	Do you feel burning, tingling, or crawling sensations in your legs while you wake up? (Y) (N)	**Score 3**
10.	Do you wake up with headaches during the night or in the morning? (Y) (N)	**Score 3**
11.	Do you have trouble falling asleep? (Y) (N)	**Score 3**
12.	Do you have trouble staying asleep once you fall asleep? (Y) (N)	**Score 4**

Add the points together that you have answered, "YES" → **Score & Risk Factor**_____

Low	Moderate	High	Severe	Very Severe
0-7	8-11	12-15	16-20	21+

Epworth Sleepiness Scale: is a questionnaire intended to measure daytime sleepiness. This can be helpful in diagnosing sleep disorders. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you.

ESS Questionnaire **0 = never doze, 1 = slight chance, 2 = moderate chance, 3 = high chance** – Please circle a number for each situation				
Situation	**Chance of dozing**			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in public (movie, meeting)	0	1	2	3
As a passenger in a car for an hour without break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch	0	1	2	3
In a car, while stopped in traffic	0	1	2	3
	Total:			

Patient Consent I hereby consent to the disclosure of my response to the Sleep Apnea Questionnaire for the purpose of assisting in the survey & diagnosis and treatment of a potential sleep disorder. I understand that as a part of this organization's treatment, and health care operations, to disclose my protected health information to my personal physician, and I consent to such disclosure for the permitted uses, including, but not limited to, disclosures via fax. I fully understand and accept the terms to this consent.

Patient Signature: _____ Date: _____

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