

# Sleep Disorder Symptoms Assessment

Date \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Date of Birth: (M/D/Y) \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M \_\_\_\_ F \_\_\_\_  
 Insurance Plan: \_\_\_\_\_

<b>FOR OFFICE USE:</b>
Height: _____
Weight: _____
BMI: _____
Neck Size: _____
Blood Pressure: _____

<b>Please check any of the following you may have:</b>			
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Frequent Urination at Night (Nocturia)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Depression	<input type="checkbox"/> Overweight

Snoring:	Score
1. Do you snore often (3 or more nights a week)? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Don't Know</span>	____ Yes = 1
2. Is your snoring loud enough to be heard through a closed door or annoy other people? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Don't Know</span>	____ Yes = 1
3. Have you noticed or been told that during sleep, you frequently stop breathing or gasp for air? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Don't Know</span>	____ Yes = 2
(sum of all numbers checked above) <b>Total Score</b>	

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 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Do you get sleepy, or doze off, while watching TV?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. While sitting or inactive in a public place (meeting, theater)?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. As a passenger in a car for an hour without a break?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. Lying down to rest in the afternoon?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. Sitting and talking to someone?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. Sitting quietly after lunch without alcohol?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8. In a car, while stopped for a few minutes at a traffic light?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(sum of all numbers checked above) <b>Total Score</b>				

<b>CPAP:</b>
Are you currently using CPAP? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, for how long? _____