

# Sleep Disorder Questionnaire

Patient Name: \_\_\_\_\_ Height: \_\_\_\_\_  
Email: \_\_\_\_\_ Weight: \_\_\_\_\_  
Gender: M F DOB \_\_\_\_\_

- OVER 18 MILLION AMERICANS SUFFER FROM SLEEP APNEA
- PEOPLE WITH SLEEP APNEA ARE 3 TIMES MORE LIKELY TO BE INVOLVED IN MOTOR VEHICLE ACCIDENTS
- 90% OF SLEEP APNEA PATIENTS HAVE NOT BEEN DIAGNOSED

Do you snore?	Yes	No
Do you have high blood pressure?	Yes	No
Have you gained weight and find it difficult to lose?	Yes	No
Do you have unexplained awakenings from sleep?	Yes	No
Do you awaken from sleep gasping for air or choking?	Yes	No
Do you notice frequent twitching or jerking of legs while asleep?	Yes	No
Do you feel your sleep is not refreshing or restful?	Yes	No
Do you have a headache upon waking in the morning?	Yes	No
Do you often lay in bed unable to fall asleep?	Yes	No
Do you grind your teeth while sleeping?	Yes	No
Do you feel fatigued or find it difficult to stay awake during the day?	Yes	No

\*\*\*\*If you have answered YES to any one of the above questions please consult with your doctor\*\*\*\*

## Prior Diagnosis:

Have you been previously diagnosed with sleep apnea?	Yes	No
If Yes: When were you diagnosed approximately?	_____	
Were you put on CPAP therapy for treatment?	_____	
Are you still using your CPAP every night?	Yes	No

## Insurance:

Do you have Medical Insurance?	Yes	No	Other
If Yes, what type:	_____ HMO	_____ PPO	_____ Other

## Epworth Sleepiness Scale

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. Use the following scale to choose the most appropriate number for each situation.

Please answer with a 0 to 3

**0 = Never doze off, 1 = Slight chance of dozing, 2 = Moderate chance of dozing, 3 = High chance of dozing**

Sitting and reading	_____
Watching T.V.	_____
Sitting inactive in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
<b>Total Score</b>	_____

Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_