# Sleep Disorder Questionnaire

Patient Name: _____ Height: _____

Email: _____ Weight: _____

Gender: 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 wake up during the night and are unable to fall back asleep? | **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**

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 | _____ |
| **Total Score** | _____ |

**Doctor:** _____ **Date:**_____

**Phone:** _____ **Fax:** _____