

**Patient Name (PRINT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Section 1: Epworth Sleepiness Scale**

Please indicate how likely you are to doze off or fall asleep in the following situations:

(0=never, 1=slight, 2=moderate, 3=high chance of dozing) – CIRCLE ONE RESPONSE FOR EACH QUESTION

Sitting and reading……………………………………………………. 0 1 2 3

Watching television…………………………………………………… 0 1 2 3

Sitting in a public place……………………………………………….. 0 1 2 3

As a passenger in a car for one hour……………………………….. 0 1 2 3

Driving a car stopped for a few minutes in traffic………………….. 0 1 2 3

Sitting & talking to someone…………………………………………. 0 1 2 3

Sitting down quietly after lunch without alcohol…………………… 0 1 2 3

Lying down to rest in the afternoon…………………………………. 0 1 2 3

**Total Score: \_\_\_\_\_\_**

**Section 2: Patient Evaluation**

Fill in the blanks, circle one yes or no response for each question

No(0) Yes(1)

BMI (See Attached Chart): \_\_\_\_\_\_ Is it greater than or equal to 30? 0 1

Neck Circumference \_\_\_\_\_\_ Is it >17” (Men) or >15”(Women)? 0 1

Have you gained at least 15lbs in the past 6 months? 0 1

**Total Score: \_\_\_\_\_\_**

**Section 3: Subjective Sleep Evaluation**

Please circle one yes or no response for each question No(0) Yes(1)

Do you snore?.......................................................................................................... 0 1

You, or your spouse, would consider your snoring louder than a person talking…. 0 1

Your snoring occurs almost every night……………………………………………….. 0 1

Your snoring is bothersome to your bed partner…………………………………....... 0 1

Do you feel that in some way your sleep is not refreshing or restful?..................... 0 1

Do you wake up at night or in the mornings with headaches?................................ 0 1

Do you experience fatigue during the day and have difficulty staying awake?....... 0 1

Do you have trouble remembering things or paying attention during the day?....... 0 1

Do you have high blood pressure?......................................................................... 0 1

**Total Score: \_\_\_\_\_\_**

**Section 4: Prior Diagnosis**

No(0) Yes(1)

Have you previously been diagnosed with sleep apnea? 0 1

*If Yes:*

When were you diagnosed? (Approx mo/yr) \_\_\_\_\_\_\_\_\_\_\_\_

Were you put on CPAP Therapy for treatment? \_\_\_\_\_\_\_\_\_\_\_\_

Are you still using your CPAP every night? \_\_\_\_\_\_\_\_\_\_\_\_

**Total Score: \_\_\_\_\_\_**

**Notes:** (Please insert any notes for the doctor regarding snoring, sleep patterns or sleep apnea that you feel may be appropriate use back of page if necessary.)

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_**

CLINICAL USE ONLY

Advanced screening criteria, if yes to any below pt should be scheduled for advanced OSA screening.

\_\_\_\_\_\_ ESS Score ≥ 8? **\_\_\_\_\_** Pt. Eval ≥ 2? **\_\_\_\_\_** Subjective Sleep Eval ≥ 3? \_\_\_\_\_ Prior OSA Diagnosis ≥ 1?

**Circle one: SQ or SQA If SQA (circle one): SACALL or SABOR**

NOTES: SCANNED