Sleep Disorder Assessment

Date: ___________________________

Name: __________________________

D.O.B.: __________________________

Gender: _________________________

FOR OFFICE USE:

HEIGHT: _____________

WEIGHT: ____________

BMI: ________________

NECK SIZE: _____________

MALLAMPATI SCORE: ____________

Please check any of the following you may have:

Frequent Urination   Heart Disease   Stroke   Insomnia   Diabetes

Frequent Urination at Night (Nocturia)   Depression   Overweight

Snoring:				Score
1. Has anyone told you that you snore often?	Yes	No	Don't Know	_____ Yes = 1
2. Is your snoring loud enough to be heard through a closed door or annoy others?	Yes	No	Don't Know	_____ Yes = 1
3. Have you noticed or been told that during Sleep, you frequently stop breathing or gasp for air?	Yes	No	Don't Know	_____ Yes = 2

Total Score:

Epworth Sleepiness Scale:	Never	Rarely	Sometimes	Always
"Do you get sleepy, or doze off?"				
1. While sitting and readying?	0	1	2	3
2. While watching TV?	0	1	2	3
3. While sitting or inactive?	0	1	2	3
4. As a passenger in a car for an hour without a break?	0	1	2	3
5. Lying down to rest in the Afternoon?	0	1	2	3
6. Sitting quietly after lunch Without alcohol?	0	1	2	3
7. In a car, while stopped for a				
8. few minutes at a traffic light?	0	1	2	3

CPAP:

Are you currently using a CPAP?   Yes   No   If yes, how long? _______