Sleep Assessment Form

Date : _____

This is a screening form to determine the need for a home sleep test, to see if you have a sleep disorder. How you sleep can affect your quality of life, especially your cardiovascular health. Long term sleep apnea can negatively affect your well-being, can lead to heart arrythmias, increase your chance for diabetes as well as strokes. Sleep disorders can be treated effectively.

Name : _____

DOB : _____

Phone : _____

E-mail : _____

Insurance Info : _____

Physician Name : _____

1. Have you ever been given a CPAP device? ..... Yes ___ No ___
2. If you have been given any form of CPAP, do you use it nightly? ..... Yes ___ No ___
3. Would you want other options to treat your Sleep Apnea? ..... Yes ___ No ___

Epworth Sleepiness Scale:

Using the following numbered scale, how likely are you to doze off while doing the following activities?

0 = Never 1 = Slight 2 = Moderate 3 = High (Circle one of the following numbers)

1. Being a passenger in a motor vehicle for an hour or more : 0 1 2 3
2. Sitting and talking to someone : 0 1 2 3
3. Sitting and reading : 0 1 2 3
4. Watching TV : 0 1 2 3
5. Sitting inactive in a public place : 0 1 2 3
6. Lying down to rest in the afternoon : 0 1 2 3
7. Sitting quietly after lunch without alcohol : 0 1 2 3
8. In a car, while stopped for a few minutes in traffic : 0 1 2 3

Total : _____

1. Have you been told that you snore? .....Yes ___ No ___
2. Does your family have a history of premature death in sleep? .....Yes ___ No ___
3. Do you have diabetes? ..... Yes ___ No ___
4. Have you ever been told you have coronary artery disease? ..... Yes ___ No ___
5. Do you have high blood pressure? .....Yes ___ No ___
6. Have you ever experienced irregular heart rhythms? .....Yes ___ No ___

Total : _____

1. Have you ever been diagnosed with sleep apnea? .....Yes ___ No ___
2. Do you awaken from sleep with chest pain or shortness of breath? .....Yes ___ No ___
3. Has anyone said that you seem to stop breathing while sleeping? .....Yes ___ No ___
4. Is your neck size larger than 15" (Female) or 16.5'' (Male)? ..... Yes ___ No ___

Neck Size: _____

5. Have you ever had a stroke? .....Yes ___ No ___
6. Have you ever been told you have congestive heart failure? .....Yes ___ No ___
7. Do you have, or did you ever have atrial fibrillation? .....Yes ___ No ___
8. Are you currently taking pain meds? .....Yes ___ No ___

Total : _____

Grand Total : _____

Signature: _____

Date: _____

Physician's Signature: _____

Date: _____