Sleep Study Pre-Screening Questionnaire & Epworth Sleepiness Scale

NAME: DOB:

HEIGHT: WEIGHT: GENDER: ○ M ○ F NECK SIZE:

HAVE YOU BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS?

High Blood Pressure	○YES	○ NO	Heart Disease	○YES	○ NO
Diabetes	○YES	○ NO	Lung Disease	○YES	○ NO
Insomnia	○YES	○ NO	Narcolepsy	○YES	○ NO
Morning Headaches	○YES	○ NO	Stroke	○YES	○ NO
Depression	○YES	○ NO	Sleep Apnea	○YES	○ NO
Nasal Oxygen Use	○YES	○ NO	Restless Leg Syndrome	○YES	○ NO
Sleeping Medication	○YES	○ NO	Pain Medication e.g., Vicodin, Oxycontin	○YES	○ NO

SLEEP QUESTIONS:

Do you snore?					○YES	○ NO
Is your snoring interrupted by pauses or choking?					○YES	○ NO
Has anyone ever said that you stop breathing or have pauses in your breathing during your sleep?					○YES	○ NO
Do you have problems keeping your legs still at night or need to move them to feel comfortable?					○YES	○ NO
How many hours of sleep do you usually get per night?	○ 2-4	○ 5	○ 6	○ 7	○ 8	○ 9+
Do you know the recommended amount of sleep per night is 7-9 hours?					○YES	○ NO
Do you feel fatigued, exhausted or tired?					○YES	○ NO
Do you feel that in some way your sleep is not refreshing or restful?					○YES	○ NO
Do you have periods of the day when you have trouble paying attention, remembering things or staying awake?					○YES	○ NO

EPWORTH SLEEPINESS SCALE (ESS):

0 = no chance of dozing 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

Sitting and reading?	○ 0	○ 1	○ 2	○ 3
Watching TV?	○ 0	○ 1	○ 2	○ 3
Sitting inactive in a public place (theater or meeting)?	○ 0	○ 1	○ 2	○ 3
As a passenger in a car for an hour without a break?	○ 0	○ 1	○ 2	○ 3
Lying down to rest in the afternoon when possible?	○ 0	○ 1	○ 2	○ 3
Sitting and talking to someone?	○ 0	○ 1	○ 2	○ 3
Sitting quietly after a lunch without alcohol?	○ 0	○ 1	○ 2	○ 3
In a car, while stopped for a few minutes at a traffic light?	○ 0	○ 1	○ 2	○ 3

TOTAL ESS SCORE:

Copy of Medical Insurance Card