Screening Evaluation for Sleep Disordered Breathing

Patient:_____ Date: _____

Questionnaire for Sleep Apnea and/or Snoring

Do you feel sleepy during the day? _____
How long have you been aware of your snoring? _____
Do you snore loudly at night? _____
Have you been told your breathing stops while sleeping? _____
Do you ever wake feeling like you were choking? _____
Do you wake refreshed? _____
Do you have difficulty breathing through your nose? _____
Do you often wake up with a headache? _____
Do you have to get up and use the bathroom several times at night? _____
Have you ever had a sleep study? _____
Have you gained weight lately? _____
Is your neck size over 17 inches? _____
Do you experience heartburn or acid reflux at night? _____
Do you have high blood pressure? _____
Are you irritable or depressed in the morning? _____
Do you have some repetitive limb movements or jerks? _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?
Use the following scale to choose the most appropriate number for each situation:

0	would never doze
1	slight chance of dozing
2	moderate chance of dozing
3	high chance of dozing

Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (ie. theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total	_____

Analyze your Score

0 – 7: It is unlikely that you are abnormally sleepy.
8 – 9: You have an average amount of daytime sleepiness.
10 – 15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
16 – 24: You are excessively sleepy and should consider seeking medical attention.