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.