



SLEEP-DISORDERED BREATHING SCREENING QUESTIONNAIRE



NAME: _____ D.O.B. _____
 HEIGHT: _____ WEIGHT: _____ AGE: _____ MALE _____ FEMALE _____

Epworth Sleepiness Scale

Please answer the following based on this scale:

0 = Would never fall asleep 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

Situation	Chance of Dozing
Reading	_____
Watching TV	_____
Sitting in a public place (Theater/meeting)	_____
Driving in a car stopped at a traffic light	_____
As a passenger in a car for 1 hour w/o a break	_____
During quiet time after lunch w/o alcohol	_____
Lying down to rest when circumstances permit	_____
Sitting and talking with someone	_____
Total	_____

Epworth Score: 0-7 (Normal) 8-9 (Mild) 10-15 (Moderate) > 15 (Significant Risk)

Clinical Obstructive Sleep Apnea Questionnaire

- | | | | |
|---------------------------------------------------------------------------------------|--------|------------------------------------------------------------------------|--------|
| 1. Has anyone ever told you that you snore?
If yes, how loud? 1 2 3 4 5 6 7 8 9 10 | YES NO | 10. Do you have indigestion? | YES NO |
| 2. Does Your Snoring Bother anyone? | YES NO | 11. Have you ever experienced memory loss? | YES NO |
| 3. Have you ever been told that you stop breathing while you sleep? | YES NO | 12. Do you ever awaken with intense anxiety? | YES NO |
| 4. Do you awaken gasping, choking or short of breath? | YES NO | 13. Do you experience depressed feelings? | YES NO |
| 5. Do you have trouble staying asleep once you fall asleep? | YES NO | 14. Do you notice a decreased ability to think clearly? | YES NO |
| 6. Do you have morning or daytime headaches? | YES NO | 15. Do you ever take naps?
If yes, how often per week 1 2 3 4 5 6 7 | YES NO |
| 7. Do you feel tired or fatigued during the day? | YES NO | 16. Do you notice a decreased sexual interest? | YES NO |
| 8. Have you ever nodded off or fallen asleep while driving? | YES NO | 17. Do you smoke? | YES NO |
| 9. Do you have high blood pressure? | YES NO | 18. Are you overweight? | YES NO |

Points for response to the questionnaire: YES=1 NO=0

LOW
0-2

MODERATE
3-4

HIGH
5-8

VERY HIGH
9-18

Diagnostic Sleep Study (PSG) 95810, followed by another night for CPAP titration study if positive for sleep apnea 95811.

Doctor's Signature

Contact Person's Name

Doctor's Name Printed

Fax and Phone Number