SLEEP APNEA/SNORING (for patients 18 years of age or older)

Patient Name:______________________________ Date of Birth:____________________

Do you know what sleep apnea means?	[ ] YES	[ ] NO
Have you ever been diagnosed with sleep apnea?	[ ] YES	[ ] NO
Do you now or have you ever used a CPAP machine?	[ ] YES	[ ] NO

SLEEP OBSERVATIONS:

Do you know you snore or have you ever been told you do?	[ ] YES	[ ] NO
Do you have difficulty breathing while lying on your back?	[ ] YES	[ ] NO
Do you ever wake up gasping for air?	[ ] YES	[ ] NO
Do you often feel tired or fatigued after a good nights sleep?	[ ] YES	[ ] NO
Has anyone ever noticed that you stop breathing during sleep?	[ ] YES	[ ] NO

EPWORTH SLEEP SCALE:

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Use the following scale to choose the most appropriate number for each situation. Please circle the numbers below to answer.

	Would Never doze	*Slight chance of dozing*	*Moderate chance of dozing*	*High chance of dozing*
*Sitting and reading	0	1	2	3
*Watching TV	0	1	2	3
*Sitting inactive in a public place	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	0	1	2	3
*Sitting and talking to someone	0	1	2	3
*Sitting quietly after lunch without alcohol	0	1	2	3
*In a car while stopped for a few minutes in traffic	0	1	2	3

TOTAL OF YOUR SCORE: __________