

Patient Name: _____

Date: _____

Sleep Facts

Do you have a history of snoring?

- Never
 Rarely – only once or a few times
 Sometimes – occasionally or under special circumstances
 Every night or almost every night
 Don't know

Has your bed partner ever moved, temporarily or permanently to another bedroom (or had you move to another room) due to snoring or restless sleep? **YES NO**

Have you ever been told you seem to have momentary periods during sleep when you stop breathing or breathe abnormally? **YES NO**

Do you ever gasp for air during the night? **YES NO**

Have you ever been told you kick or make disruptive movements during sleep?
YES NO

Do you have a family history of sleep apnea? **YES NO**

Epworth Sleepiness Scale

How likely are you to fall asleep in the following situations? In contrast to just feeling tired, this refers to your usual way of life in recent times. Even if you have not done some of the things recently, try to determine how the situation would affect you.

0 = never doze 1 = slight chance 2 = moderate chance 3 = high chance

Situation:	Chance of dozing:			
	0	1	2	3
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting passive in a public place (ex. Theatre 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 circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
In a car while stopped for a few minutes in traffic	0	1	2	3

TOTAL _____