SLEEP EVALUATION / CLINICALS

Today's Date: _____

Patient Name: _____ Date of Birth: _____/_____/_____

Gender: M _____ F _____ Height: _____ Weight: _____ Blood Pressure: _____

Please check any of the following you may have:			
☐ Morning Headaches	☐ Heart Disease	☐ Stroke	☐ Diabetes
☐ Frequent Urination at Night	☐ ADD/ADHD	☐ Depression	☐ Hypertension
☐ Erectile Dysfunction	☐ Fibromyalgia	☐ Overweight	☐ Heart Failure
☐ Atrial Fibrillation	☐ Renal Failure	☐ COPD	☐ GERD
☐ Grinding Teeth (Bruxism)	☐ Restless Legs (RLS)	☐ Memory Loss	☐ Low Testosterone

Please check Yes or No to the following questions:		
1. Do you snore *or* have been told that you snore?	☐ YES	☐ NO
2. Do you often feel tired, fatigued, or sleepy during the daytime?	☐ YES	☐ NO
3. Has anyone observed you stop breathing or gasp for air during your sleep?	☐ YES	☐ NO
4. Do you have or are you being treated for high blood pressure?	☐ YES	☐ NO

If you answered Yes to 2 or more of the above, please continue:

Epworth Sleepiness Scale	Never doze off	Slight chance of dozing	Moderate chance of dozing	High Chance of dozing
1. Do you get sleepy, or doze off, while sitting and reading?	0 ☐	1 ☐	2 ☐	3 ☐
2. Do you get sleepy, or doze off, while watching TV?	0 ☐	1 ☐	2 ☐	3 ☐
3. While sitting or inactive in a public place?	0 ☐	1 ☐	2 ☐	3 ☐
4. As a passenger in a car for an hour without a break?	0 ☐	1 ☐	2 ☐	3 ☐
5. Lying down to rest in the afternoon?	0 ☐	1 ☐	2 ☐	3 ☐
6. Sitting and talking to someone?	0 ☐	1 ☐	2 ☐	3 ☐
7. Sitting quietly after lunch without alcohol?	0 ☐	1 ☐	2 ☐	3 ☐
8. In a car, while stopped for a few minutes at a traffic light?	0 ☐	1 ☐	2 ☐	3 ☐
			Total Score	

Have you ever been diagnosed with Sleep Apnea?	☐ YES	☐ NO
Are you currently using CPAP? (or any other apnea/snoring device)	☐ YES	☐ NO
Are you currently taking any sleeping aids (prescribed or OTC)?	☐ YES	☐ NO
Are you currently taking any prescribed pain medication?	☐ YES	☐ NO

Untreated Sleep Disorders are related to many health *and* financial complications:

*Diabetes *Premature death *5X the risk of heart attack *2X the risk of stroke *Weight gain *6X the risk of a serious automobile accident *Increased risk of cancer *Hypertension *Depression *Erectile dysfunction *Daytime fatigue *ADHD *GERD *Decreased job performance *RLS/PLM *Increased cost of healthcare *Chronic/migraine headaches *Post-surgical complications/death *Chronic pain *Weakened immune system *Renal failure *Heart disease

Provider Signature/Initials*_____

*To be filed for reference and review in patient's chart notes