Preadmission testing – SLEEP EVALUATION QUESTIONNAIRE

Name: __________________________ Date: __________ Age ________

Your weight _______ (lb) Neck size ______ (in) Height ______ (in) BMI ______

Chief Sleep Complaint: __________________ Referring Provider: ________________

Please list past medical or surgical problems:

1. ___________________________ 3. ___________________________
2. ___________________________ 4. ___________________________

Have you been diagnosed or experienced:  PLEASE CHECK ANY OR ALL IF YES:

◆ Anxiety  ◆ Snoring  ◆ Daytime sleepiness
◆ Insomnia  ◆ Morning headaches  ◆ Prior sleep study
◆ Depression  ◆ Nightmares  ◆ Restless legs
◆ Panic attacks  ◆ Posttraumatic stress disorder
◆ Claustrophobia  ◆ Apnea (holding breath while asleep)

EPWORTH SLEEPINESS SCORE:
What is the chance of dozing or sleeping?

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

Rate the following situations BY CIRCLING A NUMBER for each.

Sitting or reading  0  1  2  3
Watching TV  0  1  2  3
Sitting inactive in a public place  0  1  2  3
Lying down in the afternoon  0  1  2  3
Sitting and talking to someone  0  1  2  3
Sitting quietly after lunch (no alcohol)  0  1  2  3
Stopped for a few minutes in traffic While driving  0  1  2  3
Being a passenger in a motor vehicle for an hour or more  0  1  2  3

TOTAL SCORE (add the numbers) ___________