Preadmission testing – SLEEP EVALUATION QUESTIONNAIRE

Name: _____Date: _____Age_____ **S**

Your weight _____ (lb) Neck size _____ (in) Height _____ (in) BMI _____

Chief Sleep Complaint: _____ Referring Provider: _____ **T**

Please list past medical or surgical problems:

1. _____3. _____ **O**

2. _____ 4. _____

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

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

EPWORTH SLEEPINESS SCORE:

What is the chance of dozing or sleeping?

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

Rate the following situations BY CIRCLING A NUMBER for each.

Sitting or reading	0	1	2	3	
Watching TV	0	1	2	3	**A**
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	**N**
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	**G**

TOTAL SCORE (add the numbers) _____