Sleep Study Screening Form

PATIENT NAME:______________________________ DOB______________________

BMI: ____________ AGE: __________ SEX: Male ☐ Female ☐

STOP QUESTIONNAIRE

	YES	NO
1. Snoring – Do you snore loudly?	☐	☐
2. Tired – Do you often feel tired, fatigued, or sleep during the day?	☐	☐
3. Observed – Has anyone observed you stop breathing (choking, gasping) during sleep?	☐	☐
a. Disruptive or restless sleep?	☐	☐
b. Non-restorative sleep?	☐	☐
c. Frequent unexplained arousals from sleep?	☐	☐
4. Pressure – Do you have, or are you being treated for high blood pressure?	☐	☐

EPWORTH SLEEPINESS SCALE

What is the chance that you would become fatigued in the following settings? Please use the scale listed to best describe your level of sleepiness and place the number in the box next to each situation.

0 = *NEVER* DOZE 1 = *SLIGHT* CHANCE 2 = *MODERATE* CHANCE 3 = *DEFINATE* CHANCE

Situation you might get sleepy in	Chance of Dozing
1. Sitting and reading	
2. Watching TV	
3. Sitting, inactive in a public place such as a church, a meeting or a theater	
4. As a passenger in a car for one hour with no break	
5. Lying down to rest in the afternoon	
6. Sitting and talking to someone	
7. Sitting quietly after lunch without alcohol	
8. As a passenger, stopped in traffic for a few minutes	
TOTAL (This is your Epworth Score)	

Any of the following Co-Morbidities:

- A.) Atrial Fibrillation (AFIB) ☐
- B.) Chronic Pulmonary Disease (COPD) ☐
- C.) Congestive Heart Failure (CHF) ☐
- D.) Coronary Artery Disease (CAD) ☐
- E.) Significant Tachycardia or Bradycardic arrhythmias ☐
- F.) Stroke or Heart Attack ☐
- G.) Type II Diabetes ☐
- H.) Central Sleep Apnea ☐
- I.) Circadian rhythm disorders ☐
- J.) Insomnia (chronic, transient, or associated with psychiatric disorder) ☐
- K.) Parasomnias (confusion w/arousals, sleepwalking, sleep terrors, or sleep related eating disorders) ☐
- L.) Narcolepsy ☐
- M.) Obesity hypoventilation syndrome ☐
- N.) Periodic Limb Movements in sleep (PLMS) ☐
- O.) Restless Leg Syndrome ☐