SLEEP EVALUATION / CLINICALS

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

Gender: M_____ F_____ Height: _____ Weight: _____ Blood Pressure: _____

Please check any of the following you may have:

☐ Diabetes	☐ Heart Disease	☐ Stroke	☐ Insomnia
☐ Frequent Urination at Night	☐ Heart Failure	☐ Depression	☐ Overweight
☐ Erectile Dysfunction	☐ Morning Headaches	☐ ADHD	☐ Hypertension
☐ Atrial Fibrillation	☐ Renal Failure	☐ Chronic Pain	☐ GERD

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 narcotic medication?	☐YES	☐NO
Are you aware of clenching or grinding your teeth?	☐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* _____ Today's Date: _____

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