SLEEP APNEA SELF TEST

Section 1: Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations: 0=never, 1=slight, 2=moderate, 3=high chance of dozing) – CIRCLE ONE RESPONSE FOR EACH QUESTION

Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting in public place	0	1	2	3
Sitting and talking to someone	0	1	2	3
As a passenger in a car for one hour	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
Sitting down quietly after lunch without alcohol	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3

Total Score:_____

If your score is greater than or = to 8, patient should be scheduled for advanced obstructive sleep apnea screening.

Section 2: Patient Evaluation

Fill in the blanks, circle one yes or no response for each question.

	NO	YES
BMI http://www.nhlbisupport.com/bmi/bminojs.htm Is it greater than or equal to 30?	0	1
Neck Circumference Is it > 17" (Men) or > 15" (Women)	0	1
Have you gained at least 15 lbs in the past 6 months?	0	1

Total Score:_____

If your score is greater than or = to 2, patient should be scheduled for advanced obstructive sleep apnea screening.

Section 3: Subjective Sleep Evaluation

Please circle one yes or no response for each question.

	NO	YES
Do you snore	0	1
You, or your spouse, would consider your snoring louder than a person talking	0	1
Your snoring occurs almost every night	0	1
Your snoring is bothersome to your bed partner	0	1
Do you feel that in some way your sleep is not refreshing or restful?	0	1
Do you wake up at night or in the mornings with headaches?	0	1
Do you experience fatigue during the day and have difficulty staying awake?	0	1
Do you have trouble remembering things or paying attention during the day?	0	1
Do you have high blood pressure?	0	1

Total Score:_____

If your score is greater than or = to 3, patient should be scheduled for advanced obstructive sleep apnea screening.

Section 4: Prior Diagnosis:

	NO	YES
Have you previously been diagnosed with sleep apnea?	0	1

If Yes:

When were you diagnosed? (Aproximate month/year:_____

Were you put on CPAP Therapy for treatment?_____

Are you still using your CPAP every night?_____

Total Score:_____

If your score is greater than or = to 1, patient should be scheduled for advanced obstructive sleep apnea screening.