



Physician's Sleep Study Questionnaire

Participant: _____ Part. ID or SSN: _____

Patient: _____ Date: _____

Age: yrs. Wt: lbs. Gender: Male Female Ht: ft. in. Neck Size: in.

History of:

Snoring Frequency: Never Occasionally Frequently Always

Loudness: (Use a scale from 1 to 10, 1 = very quiet to 10 = very loud) _____

Hypertension: Yes No

Witnessed apneas, choking or gasping: Yes No

Average number of hours of sleep per night: _____

The Epworth Sleepiness Scale

In the patient's typical daily life, how likely is s/he to doze off or fall asleep in the following situations (in contrast to just feeling tired)? If s/he has not been in these situations recently, have his/her imagine how the following situations would effect him/her.

Use the following scale to choose the most appropriate number for the situation:

0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

- Situation: _____ Lying down to rest in the afternoon when circumstances permit
_____ Sitting and reading
_____ Watching Television
_____ Sitting, inactive, in a public place (theatre, meeting, etc.)
_____ As a passenger in a car for an hour without a break
_____ Sitting and talking to someone
_____ In a car, while stopped for a few minutes in traffic
_____ Sitting quietly after lunch without alcohol
_____ Driving a car or truck for two (2) hours or more

Type of Study Requested:

- 1. Full attended sleep study, CPAP if necessary, for suspected severe sleep apnea, or for unknown cause of sleepiness.
2. Other Study: _____

Physician's Name: _____ License # _____

Address: _____

Telephone: _____ FAX _____

Physician's Signature

Date