

Adult Sleep & Breathing Questionnaire

Date: _____

Patient's Name: _____

Patient's Date of Birth: _____ Age: _____

Male _____ Female _____

Have you ever had a sleep test administered? _____ yes _____ no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? _____ yes _____ no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? _____ yes _____ no

Are you happy with your CPAP or Sleep Appliance? _____ yes _____ no

If you are not happy - why? _____

How often do you get out of bed to use the restroom during the night? _____

	Yes	No
Do you usually wake feeling tired and unrested?	<input type="checkbox"/>	<input type="checkbox"/>
Do you habitually snore?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with Hypertension/High Blood Pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often suffer from waking headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Do you regularly experience daytime drowsiness or fatigue?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have blocked nasal passages?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone observed you stop breathing during your sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever wake up choking or gasping?	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind your teeth while sleeping?	<input type="checkbox"/>	<input type="checkbox"/>
Is your neck circumference greater than 40 cm/ 15.75" ?	<input type="checkbox"/>	<input type="checkbox"/>
Is your Body Mass Index (BMI) more than 35?	<input type="checkbox"/>	<input type="checkbox"/>

BMI Formula BMI = $\frac{\text{(your weight in pounds X 703)}}{\text{(your height in inches X your height in inches)}}$

EPWORTH SLEEPINESS SCALE

Name _____ DOB _____

Date _____ Gender _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

Even if you have not done some of these things in the last month, try to imagine how they would have affected you.

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

- 0 - Would never doze
- 1 - Slight chance of dozing
- 2 - Moderate chance of dozing
- 3 - High chance of dozing

It is important that you answer each question as best as you can.

Situation

Chance of dozing (out of 3)

Sitting and reading

Watching TV

Sitting, inactive in a public place (eg. a theatre or a meeting)

As a passenger in a car for an hour without a break

Lying down to rest in the afternoon when circumstances permit

Sitting and talking to someone

Sitting quietly after a lunch without alcohol

In a car, while stopped for a few minutes in traffic

Total out of 24

Score Interpretation:

(1-10) Normal Range

(10-16) Excessively sleepy

(16-24) Abnormally sleepy