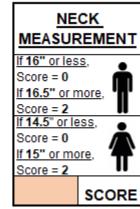
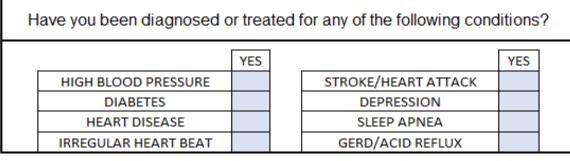
## BLUE: Patient SLEEP APNEA QUESTIONNAIRE RED: Staff FIRST NAME LAST NAME GENDER M.I. M **HEIGHT** DATE OF BIRTH WEIGHT **NECK SIZE** MONTH DAY YEAR **FEET INCHES** LBS.





DIAGNOSED or TREATED CONDITIONS	
Each '	
	SCORE

F	REQUENCY OF	SNORING & S	SLEEP DISTUR	RBANCES	
	For each question	below, select one	of the following res	ponses.	
	<pre>0 = NEVER 1 = RARELY</pre>	2 = SOMETIME 3 = FREQUENT	cuarro.	4 = ALWAYS	
In the last 6 n	nonths, how often ha	ve you snored or be	en told that you sno	ore?	
0	1	2	3	4	
In the last 6 n	nonths, have you awa	ken choking or gas	ping for air, or been	told that you did?	
0	1	2	3	4	
in the last 6 n	nonths, have you bee	n <mark>told that you</mark> stop	ped breathing while	you were sleeping	g?
		_			

**EPWORTH SLEEPINESS SCALE** 

FREQUENCY OF SNORING & SLEEP DISTURBANCES

Total of all 3 questions

SCORE

Indicate how likely you ar	re to doze off or fall asleep in t	he follo	wing sit	uations.	
0 = Would Never Doze Off 1 = Slight Chance of Dozing	2 = Moderate Chance of Do 3 = High Chance of Dozing	zing			
		EPWO	EPWORTH SCALE SCORE		
		0	1	2	3
Sitting and reading					
Watching TV					
Sitting, inactive in a public place (	park, meeting, theater, etc.)				
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 with someone					
Sitting quietly after lunch (without alcohol)					
In a car, while stopped for a few m	inutes in traffic				

EPWORTH SLEEPINESS SCALE		
If total score is  11 or less,  Score = 0		
If total score is  12 or more,  Score = 2		
SCORE		

PATIENT SIGNATURE DATE SLEEP APNEA RISK LEVEL

TOTAL