



Downtown Denver Sleep Solutions
 303/ DRSLEEP (303/ 377-5337)
 www.coloradosleepapnea.com

SLEEP STUDY PRE-SCREENING QUESTIONNAIRE & EPWORTH SLEEPINESS SCALE

FIRST NAME:	DATE:	HEIGHT:
MIDDLE INT:	GENDER: <input type="checkbox"/> M <input type="checkbox"/> F	WEIGHT:
LAST NAME:	DOB:	NECK SIZE:

HAVE YOU BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS?

High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Lung Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Insomnia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Narcolepsy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Morning Headaches	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO
Depression	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sleep Apnea	<input type="checkbox"/> YES <input type="checkbox"/> NO
Nasal Oxygen Use	<input type="checkbox"/> YES <input type="checkbox"/> NO	Restless Leg Syndrome	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sleeping Medication	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pain Medication (e.g., Vicodin, Oxycontin)	<input type="checkbox"/> YES <input type="checkbox"/> NO

SLEEP QUESTIONS:

Do you snore?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is your snoring interrupted by pauses or choking?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has anyone ever said that you stop breathing or have pauses in your breathing during your sleep?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you wear a CPAP?	<input type="checkbox"/> YES <input type="checkbox"/> NO
How many hours of sleep do you usually attain per night?	<input type="checkbox"/> 2-4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9
Do you know the recommended amount of sleep per night is 7-9 hours?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you feel fatigued, exhausted or tired?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you feel that in some way your sleep is not refreshing or restful?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have periods of the day when you have trouble paying attention, remembering things or staying awake?	<input type="checkbox"/> YES <input type="checkbox"/> NO

EPWORTH SLEEPINESS SCALE (ESS):

Chance of dozing:				
0 = NONE	1 = SLIGHT	2 = MODERATE	3 = STRONG	
While sitting or reading?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Watching TV?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting inactive in a public place (theater or meeting)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
As a passenger in a car for an hour without a break?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Lying down to rest in the afternoon when possible?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting and talking to someone?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting quietly after a lunch without alcohol?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
In a car while stopped for a few minutes at a traffic light?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
TOTAL ESS SCORE:				