SLEEP STUDY PRE-SCREENING QUESTIONNAIRE & EPWORTH SLEEPINESS SCALE

FIRST NAME:	DATE:	HEIGHT:
MIDDLE INT:	GENDER: ☐ M ☐ F	WEIGHT:
LAST NAME:	DOB:	NECK SIZE:

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

High Blood Pressure	☐ YES	☐ NO	Heart Disease	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Lung Disease	☐ YES	☐ NO
Insomnia	☐ YES	☐ NO	Narcolepsy	☐ YES	☐ NO
Morning Headaches	☐ YES	☐ NO	Stroke	☐ YES	☐ NO
Depression	☐ YES	☐ NO	Sleep Apnea	☐ YES	☐ NO
Nasal Oxygen Use	☐ YES	☐ NO	Restless Leg Syndrome	☐ YES	☐ NO
Sleeping Medication	☐ YES	☐ NO	Pain Medication (e.g., Vicodin, Oxycontin)	☐ YES	☐ NO

SLEEP QUESTIONS:

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

EPWORTH SLEEPINESS SCALE (ESS):

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