



Name: _____

Date of Birth: _____

Preferred Contact Method: _____

Preferred Time of Contact: _____

How likely are you to doze off or fall asleep in the following situations? (Even if you have not done some of these things recently, try to determine how they would have affected you.)

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

0= Would never doze or sleep

1= Slight chance of dozing or sleeping

2= Moderate chance of dozing or sleeping

3= High chance of dozing or sleeping

SITUATION	PLEASE CIRCLE ONE
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting inactive in a public place (such as a play)	0 1 2 3
Being a passenger in a motor vehicle for an hour or more	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (with no alcohol)	0 1 2 3
Stopped for a few minutes in traffic while driving	0 1 2 3
	Total:

Score of 10 or more indicates excessive daytime sleepiness.

Check all that apply:

- | | |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Sleepwalking, Sleep Talking, or other abnormal actions during sleep |
| <input type="checkbox"/> Morning Headaches | <input type="checkbox"/> Wake up choking or gasping |
| <input type="checkbox"/> Trouble staying asleep or restless sleep | <input type="checkbox"/> Acting out dreams |
| <input type="checkbox"/> Been told you stop or pause breathing | <input type="checkbox"/> Itching, crawling, or tingling feeling in legs |
| <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Limb/leg movements or jerks |
| <input type="checkbox"/> Vivid life-like dreams | <input type="checkbox"/> Fallen asleep at work, school, or while driving |
| <input type="checkbox"/> Un-refreshed in the morning | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Low Testosterone | <input type="checkbox"/> Found yourself unable to move for a short time upon falling asleep or waking up |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Body Mass Index of 30 or more |
| <input type="checkbox"/> Been diagnosed with a sleep disorder in the past | <input type="checkbox"/> Cardiac Arrhythmia |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Previous Heart Attack |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Previous Stroke | |
| <input type="checkbox"/> Congestive Heart Failure | |

Patient/Spouse/Guardian Signature

Date