PATIENT INFORMATION

Patient's Name: _____ (LAST) _____ (FIRST) ___ (M.I.) Date: _____

DO I HAVE SLEEP APNEA?

To find out if you might have the signs or symptoms of sleep apnea, complete the following screening tests below. If you have any questions about the Epworth Sleepiness Scale or Apnea Risk Assessment or you are experiencing troubled sleep, please consult with your physician during your visit.

EPWORTH SLEEPINESS SCALE (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not experienced these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = **never** doze 1 = **slight** chance of dozing 2 = **moderate** chance of dozing 3 = **high** chance of dozing

SCORE	CHANCE OF DOZING	SCORE	CHANCE OF DOZING
_____	Sitting and reading	_____	Watching TV
_____	Sitting, inactive in a public place (e.g. a theatre or meeting)	_____	As a passenger in a car for an hour without a break
_____	Lying down 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
		_____	*EPWORTH SLEEPINESS SCALE (ESS) SCORE*

APNEA RISK ASSESSMENT

1. Do you have a history of snoring?
   - _____ Severe/Consistent (5)
   - _____ Moderate/Inconsistent (3)
   - _____ Mild (2)
   - _____ No (0)

2. Have you ever been told that you have "pauses" in breathing during sleep?
   - _____ Severely so (10)
   - _____ Yes, inconsistent but most nights (8)
   - _____ Yes, but infrequent (6)
   - _____ No (0)

3. Are you overweight?
   - _____ Yes > 50 lbs. (4)
   - _____ Yes 20-50 lbs. (2)
   - _____ Yes < 20 lbs. (1)
   - _____ No (0)

4. Evaluate your degree of sleepiness using the Epworth Sleepiness Scale Above
   - _____ Score > 19 (8)
   - _____ Score 14-18 (5)
   - _____ Score 9-13 (2)
   - _____ Score < 8 (0)

5. Does your medical history include any of the following?
   - _____ High blood pressure (5)
   - _____ Heart disease (3)
   - _____ Morning headache (3)
   - _____ Stroke (3)
   - _____ >3 awakenings/night (2)
   - _____ Excessive fatigue (2)
   - _____ Depression (1)
   - _____ Problems concentrating (1)

   _____ *RISK ASSESSMENT SCORE*

AM I AT RISK FOR SLEEP APNEA?

EPWORTH SLEEPINESS SCALE (ESS) KEY

SCORE		SUGGESTED FOLLOW-UP
1 - 6	-	Congratulations, you are getting enough sleep
7 - 8	-	Your score is average
≥ 9	-	Seek the advice of a sleep specialist without delay
_____	-	

APNEA RISK ASSESSMENT KEY

SCORE		SUGGESTED FOLLOW-UP
5 - 9	-	Discuss complaints with your doctor
10 - 14	-	Discuss with your doctor (consider evaluation)
15 - 19	-	Sleep consultation or sleep study suggested
> 20	-	At risk of OSA. Sleep study should be scheduled

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