TheHeartGroup
Cardiovascular Associates Inc.

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To Our Patients:

Your physician requests that you complete this Sleep Disorder Assessment Form. This form evaluates the need for you to have a user-friendly home sleep test. The test will determine if you have Sleep Apnea. Sleep Apnea is a medical problem and is associated with many other fatal diseases in that it reduces the oxygen to the body. The current standard of care is for physicians to screen and diagnose. Sleep Apnea can be treated effectively.

Patient Name:_____ **Date of Birth:**_____

○ **Male**
○ **Female** **Height:**_____ Feet_____Inches **Weight:**_____Pounds **Neck Size:**_____

MEDICAL CONDITIONS: Have you been diagnosed or treated with any of the following conditions?

High Blood Pressure:	Y	N	Stroke:	Y	N
Heart Disease:	Y	N	Depression:	Y	N
Diabetes:	Y	N	Sleep Apnea:	Y	N
Lung Disease:	Y	N	Nasal Oxygen Use:	Y	N
Insomnia:	Y	N	Restless Leg Syndrome:	Y	N
Narcolepsy:	Y	N	Morning Headaches:	Y	N
Sleep Medication:	Y	N	Pain Medication:	Y	N

EPWORTH SLEEPINESS SCALE: 0= Would never doze 1 1= Slight chance of dozing 12 = Moderate chance of dozing I 3 = High chance of dozing

Situation:	**Chance of Dozing:**				
1. Sitting and reading	0	1	2	3	
2. Watching Television	0	1	2	3	
3. Sitting inactive in a public place, such as, in a theater or meeting	0	1	2	3	
4. As a passenger in a car for an hour without a break	0	1	2	3	**Total:**_____
5. Lying down to rest in the afternoon	0	1	2	3	
6. Sitting and talking to someone	0	1	2	3	
7. Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3	
8. In a car, while stopped for a few minutes in traffic	0	1	2	3	

HABITS:	**Never**	**Rarely 0-1 times/wk**	**Sometimes 1-2 times/wk**	**Frequently 3-4 times/wk**	**Always 5-7 times/wk**
On average in the past month, how often have you snored or been told that you snore?					
Do you wake up choking or gasping?					
Have you ever been told you stop breathing in your sleep or wake up choking or gasping?					
Do you have problems keeping your legs still at night or need to move them to feel comfortable?					

Patient Signature:_____ **Date:**_____