Sleep Disorder Assessment

Your physician is requesting that you complete this Sleep Assessment Form. This form determines the need for you to have a sleep test, which will evaluate if you have a sleep disorder. Sleep Disorders negatively affect your cardiovascular health and well being, but can be effectively treated.

Date ___________ **Name**: ____

Phone Number _____________ **Physician Name**: _____________________

Home Address____

***Part 1*.**

1. Have you ever been told you have Congestive Heart Failure? Yes ___ No ___
2. Have you ever been told you have Coronary Artery Disease? Yes ___ No ___
3. Have you ever had a stroke? Yes ___ No ___
4. Do you take 2 or more medications for high blood pressure? Yes ___ No ___
5. Have you ever experienced irregular heart rhythms (atrial fibrillation) Yes ___ No ___
6. Have you ever been told that you stop breathing at night? Yes ___ No ___
7. Do you have Diabetes? Yes___ No____

Part 2

1. Have you been told that you snore loudly? Yes ___ No ___
2. Do you awaken from sleep with chest pain or shortness of breath? Yes ___ No ___
3. Does your family have a history of premature death in sleep? Yes ___ No ___
4. Is your neck size larger than 15.5 (female) or 17.0 (male) Yes ___ No ___
5. Have you ever been diagnosed with Obstructive Sleep Apnea? Yes ___ No ___
6. Are you currently being treated for sleep apnea? Yes ___ No ___

6a. If #6 is yes, are you using your apparatus every night? Yes ___ No____

Epworth Sleepiness Scale

How likely are you to doze off while doing the following activities? Please use the following scale: 0 = never, 1 = slight, 2 = moderate, 3 = high. Circle one of the following numbers

1. Being a passenger in a motor vehicle for an hour or more 0 1 2 3
2. Sitting and talking to someone…………………. 0 1 2 3
3. Sitting and reading……………………………… 0 1 2 3
4. Watching TV…………………………………… 0 1 2 3
5. Sitting inactive in a public place………………. 0 1 2 3
6. Lying down to rest in the afternoon……………… 0 1 2 3
7. Sitting quietly after lunch without alcohol…… 0 1 2 3
8. In a car, while stopped for a few minutes in traffic… 0 1 2 3

Total score _________

Sleep test ordered: Yes No **Test type: HST PSG**

Physician Signature: ___________________________________ **Date:** _____________________