SLEEP INTAKE QUESTIONNAIRE

Patient Information

Last	First	MI	Date of Birth	Male or Female

Height	Weight	Neck size	BMI	Phone

Street Address	City	ST	Zip	Primary Care Physician

Emergency Contact:	Relationship to patient:	Phone

Type of Insurance ☐ HMO ☐ PPO ☐ Medicare ☐ Tricare☐ N/A	Name of Insurance Carrier	Group Number	Member ID Number

Have you ever had a sleep study? Yes No	If so, where was it performed?	Date	Ever been diagnosed with Sleep Apnea? Yes No

Do you own a CPAP? Yes No	If so, do you use your CPAP? Yes No	If not, please explain why?	Interested in a oral appliance to treat your sleep apnea? Yes No

Loud snoring		High blood pressure		Heart disease		Diabetes		Depression		Thyroid disease		Stroke	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

COPD		Restless leg syndrome		Insomnia		Morning Headaches		Night time urination	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

Epworth Sleepiness Questionnaire

Use the following scale to choose the most appropriate number for the situation.

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

Sitting and reading	0	1	2	3
Sitting inactive in a public place	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 permitted	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quitely after lunch without alcohol	0	1	2	3
In a car while stopped for a few minutes in traffic	0	1	2	3
Watching TV	0	1	2	3

Total Score _____

With the help of a bed partner please circle one of the following as it applies to a typical night

Snoring----------	Nightly	Weekly	Rarely	Never
Observed pauses in breath----------	Nightly	Weekly	Rarely	Never
Restless or interrupted sleep----------	Nightly	Weekly	Rarely	Never
Awaken short of breath gasps, or snorts----------	Nightly	Weekly	Rarely	Never
Awaken Coughing----------	Nightly	Weekly	Rarely	Never
Difficulty falling asleep----------	Nightly	Weekly	Rarely	Never
Leg or body jerks----------	Nightly	Weekly	Rarely	Never
Teeth grinding----------	Nightly	Weekly	Rarely	Never
Vivid dreams----------	Nightly	Weekly	Rarely	Never
Headache----------	Nightly	Weekly	Rarely	Never
Acid indigestion----------	Nightly	Weekly	Rarely	Never
Night sweats----------	Nightly	Weekly	Rarely	Never
Heart palpitations----------	Nightly	Weekly	Rarely	Never
Night time urination----------	Nightly	Weekly	Rarely	Never

Refreshed with morning wake up	Yes	No
Dry mouth in morning wake up	Yes	No
Sore jaw with morning wake up	Yes	No

Signature	Date