Name: ______________________________ Patient 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:

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

X ______________________________ ____________________

Patient/Spouse/Guardian Signature Date