VIRGINIA HEART
Sleep Center

Patient Name: _____ **Date:_____**

Date of Birth: _____ **Neck Size:_____**

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? How often do you feel tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to evaluate how they would affect you. Use the following scale to choose the most appropriate number for each 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
Watching TV	0	1	2	3
Sitting, inactive, in a public place (e.g., a theater or a meeting)	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 circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total: _____

Sleep Screening Questionnaire

	Please Circle			Please Circle	
Have you ever been told that you snore?	Yes	No	Do you wake up with a headache?	Yes	No
Do you have sleep attacks in which you suddenly fall asleep at inappropriate times or places?	Yes	No	When you are startled, emotional, excited, or happy do you experience extreme weakness (i.e. in your legs) or drop things?	Yes	No
Has anyone observed you stop breathing while you sleep?	Yes	No	As you fall asleep or wake up, do you feel unable to move? (paralysis)	Yes	No
Do you nap during the day?	Yes	No	As you fall asleep or wake up, do you see things that are not there? (hallucinations)	Yes	No
Any problems with sleepiness while driving?	Yes	No	Do you currently suffer from congestive heart failure?	Yes	No
Do your legs move when you sleep?	Yes	No	Do you currently suffer from Atrial Fibrillation?	Yes	No
Do you physically act out your dreams?	Yes	No	Have you suffered a stroke or heart attack in the last 30 days?	Yes	No
Do you wear a CPAP/BIPAP?	Yes	No	Do you currently suffer from COPD?	Yes	No
Have you ever had a prior sleep study?	Yes	No	Do you wear oxygen when you sleep?	Yes	No
If Yes, when and where was the study? (Please be as detailed as possible)					

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