



# SLEEP ASSESSMENT PATIENT REPORTED DATA

CLIENT NAME: \_\_\_\_\_

## Physical Characteristics

Age \_\_\_\_ DOB \_\_\_\_ Height \_\_\_\_ Weight \_\_\_\_  
Male \_\_\_\_ Female \_\_\_\_  
Neck Circumference: \_\_\_\_\_ in inches  
Post-Menopausal \_\_\_\_ Yes \_\_\_\_ No

## Medical History

Place a checkmark next to any of the following medical conditions you have been diagnosed with and/or are receiving treatment for:

High blood pressure	Heart attack / Myocardial infarction
Diabetes	Congestive heart failure
Pulmonary hypertension	Coronary artery disease
Depression	(stent / angioplasty / by-pass)
Stroke/ TIA Pacemaker	(Atrial fibrillation / SVT)
Pacemaker	None of the above
Irregular heart rhythm	

## Family History

Do you have a blood relative that has been diagnosed with obstructive sleep apnea?

Yes \_\_\_\_ No \_\_\_\_

## Symptoms

Place a checkmark next to all of the symptoms that apply to you.

Loud snoring	Nighttime heartburn/ Reflux
Nighttime choking/ gasping	Daytime sleepiness
Waking up frequently	Dry / sore throat when you wake up
Restless sleep/tossing during the night	Night sweats
Morning headaches	Bed torn apart
Frequent urination during sleep hours	

## Sleep Habits

Weekday: Normal bedtime \_\_\_\_\_ Normal time to get up \_\_\_\_\_  
Caffeinated beverages: \_\_\_\_ 0-1 daily \_\_\_\_ 2-4 daily \_\_\_\_ 5 or more daily  
Do you use caffeine to help you wake up? \_\_\_\_ Yes \_\_\_\_ No  
Has your bed partner left the bedroom because of loud snoring? \_\_\_\_ Yes \_\_\_\_ No

*sleep assessment continues on next page*

You cannot perform the Itamar Watch-Pat test if you have a pacemaker. You must be off all alpha-blockers 24 hours prior to test and short acting nitrates 3 hours prior to test, Check with your physician if this is safe for you to do.

Please list current prescription and over-the-counter medications including dosages.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Epworth Sleepiness Assessment**

Use the table below to assign a score to the likelihood of falling asleep in the following commonly encountered situations.

LIKELIHOOD OF DOZING	NONE 0	LOW 1	MODERATE 2	HIGH 3
Sitting and reading				
Watching television				
Sitting inactive in a public place (church, theater)				
As a passenger in a car for more than an hour without stopping				
Lying down to rest in the afternoon				
Sitting and talking to someone				
Sitting quietly after lunch (no alcohol)				
In a car, stopped for a few minutes in traffic				

**TOTAL SCORE:** \_\_\_\_\_

Completing the entire packet as accurately as possible will ensure the most reliable assessment of your risk for obstructive sleep apnea. The Sleep Service Center and affiliates cannot be held responsible for inaccurate customer reported data and misrepresentation.

I hereby certify that all information provided is accurate and is mine. All related testing activities will be conducted on me.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**COMPLETE AND ENCLOSE THIS DOCUMENT IN RETURN PACKAGE**