



Delaware Sleep Disorder Centers

Partners For Sleep Health

PLEASE ANSWER ALL QUESTIONS and give to your physician

First name	Middle Initial	Last Name		
Neck size/ Collar size (Inches)	DOB	Height	Weight	Male <input type="checkbox"/> Female <input type="checkbox"/>
If Neck Size ≥ 16.5 Males / ≥ 15.0 Females, score = 2				Score

Section 1

Have you been diagnosed or treated for any of the following conditions?					Yes = 1 No = 0
High Blood Pressure	Yes	No	Depression	Yes	No
Heart Disease	Yes	No	Sleep Apnea	Yes	No
Diabetes	Yes	No	Stroke	Yes	No
Total all Yes responses					Score

Section 2

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 work out how they would have affected you. Use the following scale to enter the most appropriate number for each situation. (M.W. Johns, Sleep 1991)

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

	Value	
Sitting and reading		
Watching TV		
Sitting, inactive, in a public place (theater, meeting, etc)		
As a passenger in a car for an hour without a break		
Lying down to rest in the afternoon when circumstances permit		
Sitting and talking to someone		
Sitting quietly after lunch without alcohol		
In a car, while stopped for a few minutes in traffic		
Total		Score
Total all values. If Total is less than 8 Score = 0, if 8-11 Score = 1, and if 12 or more Score = 2.		

Section 3

1. On average in the past month, how often have you snored or been told you snore?					
Never Score = 0	0-1 times/week Score = 0	1-2 times/week Score = 1	3-4 times/week Score = 2	5-7 times/week Score = 3	Score
2. Have you been told you stop breathing in your sleep?					
Never Score = 0	0-1 times/week Score = 0	1-2 times/week Score = 1	3-4 times/week Score = 2	5-7 times/week Score = 3	Score
3. Do you wake up choking or gasping?					
Never Score = 0	0-1 times/week Score = 0	1-2 times/week Score = 1	3-4 times/week Score = 2	5-7 times/week Score = 3	Score

Total of all scores in all shaded boxes	
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If Total of all scores is greater than 5, complete the following questions and give this form to your physician.

1. Are you currently seeing a sleep specialist for treatment? Y / N (circle one)
2. Have you had a sleep study in the last 12 months? Y / N (circle one)