

Sleep & Breathing Questionnaire | **ADULTS**

Date: _____

Patient's Name: _____

Patient's Date of Birth: _____ Age: _____

Male ☐ Female ☐

Have you ever had a sleep test administered? _____ yes _____ no

If yes, when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? _____ yes _____ no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? _____ yes _____ no

Are you happy with your CPAP or Sleep Appliance? _____ yes _____ no

If you are not happy, why? _____

How often do you get out of bed to use the restroom during the night? _____

	YES	NO
Do you usually wake feeling tired and unrested?	<input type="checkbox"/>	<input type="checkbox"/>
Do you habitually snore?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with Hypertension/High Blood Pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often suffer from waking headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Do you regularly experience daytime drowsiness or fatigue?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have blocked nasal passages?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone observed you stop breathing during your sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever wake up choking or gasping?	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind your teeth while sleeping?	<input type="checkbox"/>	<input type="checkbox"/>
Is your Body Mass Index (BMI) more than 35?	<input type="checkbox"/>	<input type="checkbox"/>

BMI Formula

BMI = $\frac{\text{(your weight in pounds X 703)}}{\text{(your height in inches X your height in inches)}}$

Is your neck circumference greater than 40 cm? ☐ ☐

Patient Name: _____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 choose the most appropriate number for each situation:

- 0 = no chance of dozing
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (like a theater or a meeting)	_____
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 a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL SCORE	_____

Analyse Your Score

Interpretation:

- | | |
|------------|---|
| From 0-7 | It is unlikely that you are abnormally sleepy |
| From 8-9 | You have an average amount of daytime sleepiness |
| From 10-15 | You may be excessively sleepy, depending on the situation. You may want to consider seeking medical attention |
| From 16-2 | You are excessively sleepy and should consider seeking medical attention |