Weisfogel Sleep Disorder Assessment

Your physician requests that you complete this Sleep Disorder Assessment Form. This form evaluates the need for you to have a sleep test. The sleep test will determine if you have a sleep disorder. Sleep disorders negatively affect your well-being, especially your cardiovascular health. Sleep disorders can be treated effectively.

Date: _____Name: _____ Date of Birth_____

Phone Number _____Physician Name: _____

1. Have you ever been given a CPAP device?..... Yes ___ No___
2. If you have been given any form of CPAP, do you use it nightly?..... Yes ___ No___
3. Are you comfortable with your CPAP and satisfied with its use?..... Yes___ No___

If the answer is "Yes" to all three questions, YOU ARE DONE!

If your answer is **"No"** to any of the above questions, please continue to ***Part 1***.

Part 1 ***Epworth Sleepiness Scale***

How likely are you to doze off while doing the following activities? Please use the following scale:
0 = never, 1 = slight, 2 = moderate, 3 = high. Circle one of the following numbers

1. Being a passenger in a motor vehicle for an hour or more. …….. 0 1 2 3
2. Sitting and talking to someone…… 0 1 2 3
3. Sitting and reading…….. 0 1 2 3
4. Watching TV……... 0 1 2 3
5. Sitting inactive in a public place……. 0 1 2 3
6. Lying down to rest in the afternoon……... 0 1 2 3
7. Sitting quietly after lunch without alcohol…….. 0 1 2 3
8. In a car, while stopped for a few minutes in traffic……. 0 1 2 3

Total ESS: ____

Part 2

1. Have you been told that you snore?..... Yes___ No___
2. Does your family have a history of premature death in sleep?..... Yes___ No___
3. Do you have diabetes?..... Yes___ No___
4. Have you ever been told you have coronary artery disease?..... Yes___ No___
5. Do you have high blood pressure?..... Yes___ No___
6. Have you ever experienced irregular heart rhythms?..... Yes___ No___

Part 3

1. Have you ever been diagnosed with sleep apnea? …….. Yes___ No___
2. Do you awaken from sleep with chest pain or shortness of breath? Yes___ No___
3. Has anyone said that you seem to stop breathing while sleeping? .. Yes___ No___
4. Is your neck size larger than 15" (female) or 16.5" (male)……. Yes___ No___
5. Have you ever had a stroke?..... Yes___ No___
6. Have you ever been told you have congestive heart failure?..... Yes___ No___
7. Do you have or did you ever have atrial fibrillation?..... Yes___ No___

Actual Neck Size:

Physician Signature:_____ Date:_____