

Sleep Disorder Screening

Assessment: Dr. Malan requests that you complete this Sleep Disorder Assessment Form. This form evaluates the need for you to have a user-friendly home sleep test. The home 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 with an Oral Device or CPAP machine.

Date: _____ Name: _____ Date of Birth _____
Phone Number _____ Physician Name: _____
Home Address _____

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 snoring affect the relationship with your partner?..... Yes ___ No ___

Part 3

1. Have you ever been diagnosed with sleep apnea? Yes ___ No ___
2. Has anyone said that you seem to stop breathing while sleeping? .. Yes ___ No ___
3. Is your neck size larger than 15" (female) or 16.5" (male)..... Yes ___ No ___

Part 4

ALL OF THE FOLLOWING MEDICAL CONDITIONS LISTED BELOW ARE ASSOCIATED WITH SLEEP APNEA. PLEASE CIRCLE THE ONES THAT APPLY TO YOU:

STROKE HEART DISEASE TYPE 2 DIABETES ACID REFLUX/GERD FREQUENT NIGHTTIME URINATION
A-FIB HIGH BLOOD PRESSURE DEMENTIA OBESITY SEXUAL DYSFUNCTION ANXIETY/DEPRESSION

OTHER:

Physician Signature: _____ Date _____

