Camino Dental Group Modified Epworth Sleepiness Scale

Your physician is requesting that you complete this Sleep Assessment Form. This form determines the need for you to have a user-friendly home sleep test, which will evaluate if you have a sleep disorder. Sleep Disorders include snoring will negatively affect your well-being but can be effectively treated.

Date: _____ Name:_____ Date of Birth:_____

Phone: (Home)_____(Cell) _____Best Call Time(s): _____

Email: _____ Insurance:_____PPO( ) HMO( ) Kaiser( ) Medicare( )

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 your answer is NO to any of the above questions, please continue to Part 1.
If the answer is Yes to all, PLEASE STOP.

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 score	_____

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 ____
8.	Have you been taking pain medications such as narcotics/opioids?	Yes ____ N0 ____

Staff Only: **Actual Neck Size: _____ Height: _____ Weight: _____ BMI: _____**

Physician Signature:_____ Date:_____