SLEEP BREATHING DISORDERS

First and Last Name________________________________Birth Date ______/_______/______

(please print) month day year

SYMPTOMS FOR WHICH YOU ARE SEEKING TREATMENT

Please number in order of seriousness

	CPAP Intolerance		Significant daytime drowsiness
	Difficulty falling asleep		Sleepiness while driving
	Fatigue		Witnesses apneic events
	Frequent heavy snoring		Morning Headache
	Frequent heavy snoring which affects the sleep of others		Leg Movements/Restless legs
	Insomnia		Teeth Grinding
	Gasping when waking up		Limited Mouth Opening
	Nighttime choking spells		

Other: Please write in

EPWORTH SLEEP QUESTIONNAIRE

How likely are you to doze off or fall asleep in the following situations?

Never chance of dozing	**Slight** chance of dozing	**Moderate** chance of dozing	**High** chance of dozing	
❑	❑	❑	❑	Sitting and reading
❑	❑	❑	❑	Watch TV
❑	❑	❑	❑	Sitting inactive in public place (e.g. a theatre or a meeting)
❑	❑	❑	❑	As a passenger in a car for an hour without a break
❑	❑	❑	❑	Lying down 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

Never = 0	Moderate=2	**Total Score: ______**	
Slight = 1	High=3	0-9 : Normal	10 or more: Consider seeking medical attention