

AIRWAY & SLEEP EVALUATION FORM

First Name		Middle Initial		Last Name	
Weight	Pounds	Age	Years	Gender	
				Male <input type="radio"/> Female <input type="radio"/>	
Height	Feet	Inches	Neck Size	Inches	
Date of Birth	Month	Day	Year	ID Number	Optional

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?					
High blood pressure	Yes <input type="radio"/>	No <input type="radio"/>	Stroke	Yes <input type="radio"/>	No <input type="radio"/>
Heart disease	Yes <input type="radio"/>	No <input type="radio"/>	Depression	Yes <input type="radio"/>	No <input type="radio"/>
Diabetes	Yes <input type="radio"/>	No <input type="radio"/>	Sleep apnea	Yes <input type="radio"/>	No <input type="radio"/>
Lung disease	Yes <input type="radio"/>	No <input type="radio"/>	Nasal oxygen use	Yes <input type="radio"/>	No <input type="radio"/>
Insomnia	Yes <input type="radio"/>	No <input type="radio"/>	Restless leg syndrome	Yes <input type="radio"/>	No <input type="radio"/>
Narcolepsy	Yes <input type="radio"/>	No <input type="radio"/>	Morning Headaches	Yes <input type="radio"/>	No <input type="radio"/>
Sleeping Medication	Yes <input type="radio"/>	No <input type="radio"/>	Pain Medication e.g., vicodin, oxycontin	Yes <input type="radio"/>	No <input type="radio"/>

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

	0 = would never doze	1 = slight chance of dozing	2 = moderate chance of dozing	3 = high chance of dozing
Sitting and reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Watching TV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting, inactive, in a public place (theater, meeting, etc)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As a passenger in a car for an hour without a break	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down to rest in the afternoon when circumstances permit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting and talking to someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting quietly after lunch without alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In a car, while stopped for a few minutes in traffic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Frequency	0 - 1 times/week	1 - 2 times/week	3 - 4 times/week	5 - 7 times/week
On average in the past month, how often have you snored or been told that you snored?				
Never <input type="radio"/>	Rarely <input type="radio"/> +1	Sometimes <input type="radio"/> +2	Frequently <input type="radio"/> +3	Almost always <input type="radio"/> +4
Do you wake up choking or gasping?				
Never <input type="radio"/>	Rarely <input type="radio"/> +1	Sometimes <input type="radio"/> +2	Frequently <input type="radio"/> +3	Almost always <input type="radio"/> +4
Have you been told that you stop breathing in your sleep or wake up choking or gasping?				
Never <input type="radio"/>	Rarely <input type="radio"/> +1	Sometimes <input type="radio"/> +2	Frequently <input type="radio"/> +3	Almost always <input type="radio"/> +4
Do you have problems keeping your legs still at night or need to move them to feel comfortable?				
Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Frequently <input type="radio"/>	Almost always <input type="radio"/>

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