

Initial Screening Form

Patient Name (PRINT) _____

Section 1: Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations:
(0=never, 1=slight, 2=moderate, 3=high chance of dozing) – CIRCLE ONE RESPONSE
FOR EACH QUESTION

Sitting and reading.....	0	1	2	3
Watching television.....	0	1	2	3
Sitting in a public place.....	0	1	2	3
As a passenger in a car for one hour.....	0	1	2	3
Driving a car stopped for a few minutes in traffic.....	0	1	2	3
Sitting & talking to someone.....	0	1	2	3
Sitting down quietly after lunch without alcohol.....	0	1	2	3
Lying down to rest in the afternoon.....	0	1	2	3
Total Score: _____				

Section 2: Subjective Sleep Evaluation

Please circle one yes or no response for each question

	No(0)	Yes(1)
Do you snore?.....	0	1
Your spouse or you, consider your snoring louder than a person talking.....	0	1
Your snoring occurs almost every night.....	0	1
Your snoring is bothersome to your bed partner.....	0	1
Do you feel that in some way your sleep is not refreshing or restful?.....	0	1
Do you wake up at night or in the mornings with headaches?.....	0	1
Do you experience fatigue during the day and have difficulty staying awake?..	0	1
Do you have trouble remembering things or paying attention during the day?.	0	1
Do you have high blood pressure?.....	0	1
Do you have diabetes?.....	0	1
Total Score: _____		

Section 3: Prior Diagnosis.....

Have you previously been diagnosed with sleep apnea? 0 1

If Yes:

When were you diagnosed? (Approx mo/yr) _____

Were you put on CPAP Therapy for treatment? _____

Are you still using your CPAP every night? _____

Total Score: _____

Patient Signature: _____ Date: ____/____/____

OFFICE USE ONLY

Advanced screening criteria, if yes to any below pt should be scheduled for advanced OSA screening.

____ ESS Score ≥ 8? ____ Subjective Sleep Eval ≥ 3? ____ Prior OSA Diagnosis ≥ 1