Sleep Assessment Questionnaire

Name: ______ **Age:** ______ **Date:** ______

Height: ______ **Weight:** ______ **BMI:** ______ **Blood Pressure:** ______ **Neck (in):** ______

PATIENT MUST COMPLETE THIS PART

Question	Yes	No
Do you snore?	☐	☐
Are you unable to stay awake in the daytime?	☐	☐
Do you wake up with a headache in the morning?	☐	☐
Do you wake up in the middle of the night unable to breathe or gasping for air?	☐	☐
Do you have sudden episodes of loss of muscle control, especially during emotional situations?	☐	☐
Do your legs jerk at night or feel restless?	☐	☐
Do you ever feel unable to move when falling asleep or awakening?	☐	☐
Have you gained a lot of weight in a short time?	☐	☐
Do you have problems falling asleep?	☐	☐
Do you have a hard time staying asleep?	☐	☐
Has someone seen you stop breathing while sleeping?	☐	☐

Do you frequently wake up with: (please circle as many as apply)

☐ Dry mouth ☐ Sore throat ☐ Headache ☐ Heartburn ☐ None

EPWORTH SLEEPINESS SCALE

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS?

0 = Would Never Doze • 1 = Slight Chance • 2 = Moderate Chance • 3 = High Chance

Situation	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (e.g., theater or meeting)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest 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	○	○	○	○

PHYSICIAN MUST COMPLETE THIS PART (check ONE and sign/date):

☐ If patient meets health plan criteria for sleep study, proceed with home sleep test (HST) if no contraindications.

☐ Proceed directly to a split-night in-lab study (PSG) — criteria must be met; request cannot be approved otherwise.

Physician Signature	Printed Name	Date