INSERT LOGO HERE

Name ◊ M ◊ F Gender DOB

Address, City, State, Zip Weight Height Neck Size

Cell Phone Alt. Phone Email

PPO Medical Insurance Company (Non-PPO) ID# Group#

Have you ever been diagnosed with a sleep disorder? ◊ YES ◊ NO Night time oxygen use? ◊ YES ◊ NO

Are you currently using a CPAP Machine? ◊ YES ◊ NO (if YES) Do you use it every night? ◊ YES ◊ NO

Answer **"YES"** or **"NO"** to the following questions (circle Yes or No answers)

◊ Y ◊ N 8 Have you ever been told you stop breathing while asleep?
◊ Y ◊ N 6 Have you ever fallen asleep or nodded off while driving?
◊ Y ◊ N 6 Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?
◊ Y ◊ N 4 Do you feel excessively sleepy during the day?
◊ Y ◊ N 4 Do you snore or have you ever been told that you snore?
◊ Y ◊ N 2 Have you had weight gain and found it difficult to lose?
◊ Y ◊ N 2 Have you taken medication for, or been diagnosed with high blood pressure?
◊ Y ◊ N 3 Do you kick or jerk your legs while sleeping?
◊ Y ◊ N 3 Do you feel burning, tingling or crawling sensations in your legs when you wake up?
◊ Y ◊ N 3 Do you wake up with headaches during the night or in the morning?
◊ Y ◊ N 4 Do you have trouble falling asleep?
◊ Y ◊ N 4 Do you have trouble staying asleep once you fall asleep?

Score and Risk Factor (Add the points that you have answered "YES")

Low	Moderate	High	Severe
0-7	8-11	12-15	16+

Dx:	**FOR OFFICE USE ONLY**		
◊ Sleep Apnea (Observed)	◊ Snoring (Habitual)	◊ Stroke	◊ Obesity
◊ OSA (Diagnosed)	◊ Gasping/Choking	◊ Heart Attack	◊ Insomnia
◊ Excessive Daytime Sleepiness	◊ Soft Tissue Abnormality (Upper Airway)	◊ Hypertension	◊ Depression

Rx:	**Other Services:**
◊ Two-night Home Sleep Study or __ -night	◊ Overnight attended Polysomnogram ◊ Sleep Specialist Consultation
◊ Diagnostic ◊ Efficacy (w/ oral appliance)	◊ CPAP/BIPAP Titration ◊ Other

NOTES:

Practice/Group Name Doctor Name

Physical Address Account Code

Phone Fax Email

State License NPI #

Dr. Signature Date Office Contact

The purpose of this questionnaire is to aid a qualified medical professional in identifying possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.