**Weisfogel Sleep Disorder Assessment**

Your physician requests that you complete this Sleep Disorder Assessment Form. This form evaluates the need for you to have a user-friendly home sleep test. The home sleep test will determine if you have a sleep disorder. Sleep disorders negatively affect your well-being, especially your cardiovascular health. Sleep disorders can be treated effectively.

**Date: \_\_\_\_\_\_\_\_\_\_\_Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_**

**Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 1. Have you ever been given a CPAP device?.......................................... Yes \_\_\_ No\_\_\_

 2. If you have been given any form of CPAP, do you use it nightly?....... Yes \_\_\_ No\_\_\_

 3. Are you comfortable with your CPAP and satisfied with its use?......... Yes\_\_\_ No\_\_\_

***If the answer is “Yes” to all three questions, YOU ARE DONE!***

If your answer is **“No”** to any of the above questions, please continue to ***Part 1***.

 ***Part 1*  *Epworth Sleepiness Scale***

How likely are you to doze off while doing the following activities? Please use the following scale:

 0 = never, 1 = slight, 2 = moderate, 3 = high. Circle one of the following numbers

 1. Being a passenger in a motor vehicle for an hour or more. ….….. 0 1 2 3

 2. Sitting and talking to someone…………………………………… 0 1 2 3

 3. Sitting and reading……………………………………………….. 0 1 2 3

 4. Watching TV……………………………………………………... 0 1 2 3

 5. Sitting inactive in a public place…………………………………. 0 1 2 3

 6. Lying down to rest in the afternoon…………………………….... 0 1 2 3

 7. Sitting quietly after lunch without alcohol……………………….. 0 1 2 3

 8. In a car, while stopped for a few minutes in traffic………………. 0 1 2 3

 Total ESS: \_\_\_\_

***Part 2***

 1. Have you been told that you snore?................................................ Yes\_\_\_ No\_\_\_

 2. Does your family have a history of premature death in sleep?....... Yes\_\_\_ No\_\_\_

 3. Do you have diabetes?.................................................................... Yes\_\_\_ No\_\_\_

 4. Have you ever been told you have coronary artery disease?.......... Yes\_\_\_ No\_\_\_

 5. Do you have high blood pressure?.................................................. Yes\_\_\_ No\_\_\_

 6. Have you ever experienced irregular heart rhythms?...................... Yes\_\_\_ No\_\_\_

***Part 3***

 1. Have you ever been diagnosed with sleep apnea? ……………….. Yes\_\_\_ No\_\_\_

 2. Do you awaken from sleep with chest pain or shortness of breath? Yes\_\_\_ No\_\_\_

 3. Has anyone said that you seem to stop breathing while sleeping? .. Yes\_\_\_ No\_\_\_

 4. Is your neck size larger than 15” (female) or 16.5’’ (male)………. Yes\_\_\_ No\_\_\_

 5. Have you ever had a stroke?............................................................. Yes\_\_\_ No\_\_\_

 6. Have you ever been told you have congestive heart failure?........... Yes\_\_\_ No\_\_\_

Actual Neck Size:

 

 7. Do you have or did you ever have atrial fibrillation?....................... Yes\_\_\_ No\_\_\_

 8. Are you currently taking pain meds?................................................ Yes\_\_\_ No\_\_\_

Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_