California Center for Sleep Disorders

San Francisco
815 Hyde Street, 3rd Floor

Daly City
295 89th St. Suite #205

Alameda
985 Atlantic Ave. Ste #250

Concord
2485 High School Ave. Ste. #218

Fremont
2299 Mowry #2

Pleasanton
2324 Santa Rita Rd, Ste. #8

Stop Bang/ESS Questionnaire

Fax to: 510-263-3350

****** Please ATTACH the Referral form, Patient Demographics, Insurance Card, & recent relevant progress note *****

Patient Name: _____ DOB: _____

Sex: _____ Height: _____ Weight: _____

IMPORTANT QUESTIONS FOR PATIENT

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel tired, fatigued, or sleepy during daytime?	Yes	No
Has anyone observed you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood pressure?	Yes	No
Neck circumference > 15.75 inches? (measured by staff)	Yes	No

SLEEPINESS SCALE

How likely are you to *doze off or fall asleep* in the following situations, in contrast to just feeling tired? Even if you haven't done some of the activities recently, think about how they would have affected you.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important that you circle a number (0 to 3) for EACH situation.

SITUATION	CHANCE OF DOZING			
Sitting and Reading	0	1	2	3
Watching Television	0	1	2	3
Sitting inactive in a public place (theater/meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (with no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3
TOTAL SCORE	_____			

Please print, fill out and provide results to your primary care doctor to get a referral for a sleep test

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Provider Name **X**_____ Date: _____

Phone #_____ Fax #_____

Address _____