

# WATERMARK MEDICAL ARES QUESTIONNAIRE

PATIENT DEMOGRAPHICS			SCORING
Last	First	Middle Initial	Neck Size +2 ≥16.5 (Male) +2 ≥15.0 (Female) <div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto;"></div>
Date of Birth	<input type="radio"/> Male <input type="radio"/> Female	ID# <small>Optional</small>	
Height ____feet ____inches	Weight ____pounds	Neck Size ____inches	

MEDICAL CONDITIONS: Have you been diagnosed or treated for any of the following conditions?				+1 for each Yes response
High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No	Do not assign any points for these eight responses  <div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto;"></div>
Heart Disease	<input type="radio"/> Yes <input type="radio"/> No	Depression	<input type="radio"/> Yes <input type="radio"/> No	
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Sleep Apnea	<input type="radio"/> Yes <input type="radio"/> No	
Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Nasal oxygen use	<input type="radio"/> Yes <input type="radio"/> No	
Insomnia	<input type="radio"/> Yes <input type="radio"/> No	Restless legs syndrome	<input type="radio"/> Yes <input type="radio"/> No	
Narcolepsy	<input type="radio"/> Yes <input type="radio"/> No	Morning headaches	<input type="radio"/> Yes <input type="radio"/> No	
Sleep Medication	<input type="radio"/> Yes <input type="radio"/> No	Pain Medication	<input type="radio"/> Yes <input type="radio"/> No	

EPWORTH SLEEPINESS SCALE: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)					Epworth Score <b>TOTAL</b> the values from all 8 questions. If 11 or less Score = 0 If 12 or more Score = 2
0 = would never doze   1 = slight chance of dozing   2 = moderate chance of dozing   3 = high chance of dozing					
Sitting and reading	0	1	2	3	<div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto;"></div>
Watching TV	0	1	2	3	
Sitting, inactive, in a public place (theater, meeting, etc.)	0	1	2	3	
As a passenger in a car for an hour without break	0	1	2	3	
Lying down to rest in the afternoon when circumstances permit	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after lunch without alcohol	0	1	2	3	
In a car, while stopped for a few minutes in traffic	0	1	2	3	

HABITS	Never	Rarely 0-1 times/wk	Sometimes 1-2 times/wk	Frequently 3-4 times/wk	Always 5-7 times/wk	Habits Score <b>TOTAL</b> the values for all answers from first 3 habits questions  <div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto;"></div>
On average in the past month, how often have you snored or been told that you snore?	<input type="radio"/> +0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	<input type="radio"/> +4	
Do you wake up choking or gasping?	<input type="radio"/> +0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	<input type="radio"/> +4	
Have you ever been told that you stop breathing in your sleep or wake up choking or gasping?	<input type="radio"/> +0	<input type="radio"/> +1	<input type="radio"/> +2	<input type="radio"/> +3	<input type="radio"/> +4	
Do you have problems keeping your legs still at night or need to move them to feel comfortable?	<input type="radio"/> +0	<input type="radio"/> +0	<input type="radio"/> +0	<input type="radio"/> +0	<input type="radio"/> +0	

I have personally completed this questionnaire. <b>By signing this agreement</b> , you acknowledge that you have read, understand, and agree to the terms and conditions of the Patient Authorization form on the reverse side of this form.	Total all 4 boxes above.  <b>Scoring Chart</b> ≤3 = No Risk 4 or 5 = Low Risk 6 to 10 = High Risk ≥11 = Very High Risk
Patient Signature _____ Date _____	<div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto;"></div>
Patient Phone Number _____	