BERGEN HEALTH & WELLNESS

Sleep Assessment Form

Your doctor is requesting that you complete this Sleep Assessment Form. This form determines the need for you to have a user friendly home sleep test, which will test to see if you have a challenge breathing when you are sleeping. How you breathe can affect your quality of life and especially your cardiovascular health; and can be easily treated.

Name: _____ **Date of Birth** _____

OK to leave Message? Yes☐No☐ **Regular Dr's Name and Phone**: _____

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 the all of the above questions, PLEASE STOP.
If your answer is *NO* to *any* of the above questions, please continue to the following questions:

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☐ _____

Part 1

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. Have you been told that you have high blood pressure? Yes ☐ No ☐
6. Have you ever experienced an irregular heart beat? Yes ☐ No ☐ _____

Part 2

1. Are you taking opiod pain medications on a regular basis? Yes ☐ No ☐
2. Have you ever been diagnosed with sleep apnea? Yes ☐ No ☐
3. Do you awaken from sleep with chest pain or shortness of breath? Yes ☐ No ☐
4. Has anyone said that you seem to stop breathing while sleeping? Yes ☐ No ☐
5. Is your neck size larger than 15" (female) or 16.5'' (male) Yes ☐ No ☐
6. Have you ever had a stroke? Yes ☐ No ☐
7. Have you ever been told you have congestive heart failure? Yes ☐ No ☐
8. Do you have or did you ever have atrial fibrillation? Yes ☐ No ☐ _____

Neck Size: _____

Patient Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____

SA Score: _____ POS ☐ NEG ☐ HST AUTH: YES ☐ NO ☐

Submit