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 ___	**Neck Size:**
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 ___	_____

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

SA Score: _____ POS NEG HST AUTH: YES NO