Health Sleep Disorder Check-Up

Your physician is requesting that you complete this survey prior to your visit today. Once completed, please give it to the medical assistant when you are called to be taken to the exam room. If you have recently completed this survey please let the medical assistant know.

The survey is used to determine the need for you to have a sleep test. This test is to evaluate if you have a sleep disorder which is negatively affecting your cardiovascular health and well being.

First Name: _____ **Last Name:** _____

Date of Birth: ___/___/____ **Physician Name**: _____

Part 1.

1. Have you ever been told you have Congestive Heart Failure? Yes ___ No ___
2. Have you ever been told you have Coronary Artery Disease? Yes ___ No ___
3. Have you ever had a stroke? Yes ___ No ___
4. Do you take 3 or more medications for high blood pressure? Yes ___ No ___
5. Have you ever experienced irregular heart rhythms (atrial fibrillation) Yes ___ No ___
6. Have you ever been told that you stop breathing at night? Yes ___ No ___

Part 2

1. Have you been told that you snore loudly? Yes ___ No ___
2. Do you have difficulty breathing at night? Yes ___ No ___
3. Do you awaken from sleep with chest pain or shortness of breath? Yes ___ No ___
4. Does your family have a history of premature death in sleep? Yes ___ No ___
6. Is your neck size larger than 15.5 (female) or 17.0 (male) Yes ___ No ___

Part 3

1. Have you ever been diagnosed with Obstructive Sleep Apnea? Yes ___ No ___
2. Are you currently using a positive airway pressure device? Yes ___ No ___
3. If you have a device, are you using it every night? Yes ___ No ___

Part 4 _____

Chance of dozing using Epworth Sleepiness Scale (0 = never, 1 = slight, 2 = moderate, 3 = high)

1. Being a passenger in a motor vehicle for an hour or more _____
2. Sitting and talking to someone..... _____
3. Sitting and reading..... _____
4. Watching TV..... _____
5. Sitting inactive in a public place..... _____
6. Lying down to rest in the afternoon..... _____
7. Sitting quietly after lunch without alcohol..... _____
8. In a car, while stopped for a few minutes in traffic... _____

Total score _____

Scoring Methodology

One "Yes" in *Part 1* and one "Yes" in *Part 2* or *Part 3* consider sleep test or
If total score in *Part 4* is greater than 8, consider sleep test.

Provider Use Only: □ Reviewed, order sleep study, and titration and treatment if positive for sleep apnea.
□ Reviewed, do not order sleep study. □Reviewed, schedule sleep specialist visit

Physician Signature: _____ Date: _____