

Today's Date: \_\_\_\_\_

## Screening Questionnaire

First Name	MiddleName	LastName	DOB
Billing/Street Address		City	State Zip
Cell Phone	Home Phone	Email	
<b>Medical Insurance</b>	Policy#		

Communication Preference: [Check one]  Text  email

### Physical Basics

Male  Female Height: \_\_\_\_\_ft. \_\_\_\_\_in. Weight \_\_\_\_\_lb. Waist: \_\_\_\_\_in. Neck: \_\_\_\_\_in.

### Medical History

Have you been diagnosed with any of the following conditions?

High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Narcolepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Restless Leg Symptom	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Morning Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Night Urination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Insomnia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nasal Oxygen	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Medication	<input type="checkbox"/> Yes <input type="checkbox"/> No
CPAP	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Medication	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Years? _____ Packs/Day? _____		Location: Back <input type="checkbox"/> Leg <input type="checkbox"/> Other: _____	
Happy CPAP user?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## Do you have any of these Symptoms?

1. Have you been told, or are you aware, that you snore loudly?  Yes  No
2. Do you sometimes wake up choking or gasping?  Yes  No
3. Have you been told that you stop breathing, or have pauses in your breathing, during your sleep?  Yes  No
4. Do you wake up suddenly, for no reason, from your sleep?  Yes  No
5. Do you have periods of the day when you have trouble paying attention, remembering things, or staying awake?  Yes  No
6. Do you feel that in some way your sleep is not refreshing or restful?  Yes  No
7. Do you often feel tired, fatigued, or sleepy during daytime?  Yes  No

## How Sleepy/Tired Are You?

Almost one-third of your life should be spent in restful sleep. Being sleepy or tired affects how you think, how you feel, how you function, and your overall health. Your quality of life depends on quality sleep. When answering the questions below you should consider both how likely you are to doze and also your overall level of fatigue.

**Use the following scale to choose the most appropriate number for each situation.**

0 = Would never doze                      2 = Moderate chance of dozing  
 1 = Slight chance of dozing            3 = High chance of dozing

**What is the probability that you will face a chance of Dozing in the following situations?**

Please check the appropriate choice using the scale above

	Never	Slight	Moderate	High
1. Sitting and reading	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Watching TV	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Sitting inactive in a public place (for example, at a theatre or in a meeting)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. As a passenger in a car for an hour without a break	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. Sitting and talking to someone	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. Sitting quietly after a lunch without alcohol	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8. In a car while stopped for a few minutes in the traffic	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

For Clinical Use:

Epworth Score	
STOP	
BANG	
STOP/BANG	
Screening Status	
Consultation Date	
Assessment Status	

Dr. Figueroa \_\_\_\_\_  
 Dr. McDaniel \_\_\_\_\_  
 Dr. Orlando \_\_\_\_\_  
 Dr. White \_\_\_\_\_  
 Hygiene \_\_\_\_\_

PT ID # \_\_\_\_\_