

General Sleep Study Worksheet

Patient	Patient Name:		
	DOB:		
	Insurance Plan:	Member ID:	
	Epworth Sleepiness Score:		
	BMI:	Height:	Weight:

Complaints and Symptoms: (Check all that apply)			
<input type="checkbox"/>	Snoring	<input type="checkbox"/>	Excessive daytime sleepiness
<input type="checkbox"/>	Non-restorative sleep	<input type="checkbox"/>	Morning headaches
<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Witnessed pauses in breathing
<input type="checkbox"/>	Gasping during sleep	<input type="checkbox"/>	Frequent unexplained arousals
<input type="checkbox"/>	Decreased libido	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	Patient works night shift	<input type="checkbox"/>	Patient sleeps < 6 hrs per night
<input type="checkbox"/>		<input type="checkbox"/>	Disturbed or restless sleep
<input type="checkbox"/>		<input type="checkbox"/>	Memory loss
<input type="checkbox"/>		<input type="checkbox"/>	Choking during sleep
<input type="checkbox"/>		<input type="checkbox"/>	Nocturia
<input type="checkbox"/>		<input type="checkbox"/>	Non-ambulatory individual

Duration of Symptoms: How long has the patient been experiencing their symptoms?			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
< One month, Number of weeks:	One Month	> Six months. Number of months:	
Three Months			

Co-morbid Conditions (recent supporting documentation required)			
<input type="checkbox"/>	Idiopathic Pulmonary Hypertension	<input type="checkbox"/>	Neuromuscular weakness impaired respiratory function
<input type="checkbox"/>	Class III or IV CHF	<input type="checkbox"/>	Stage III or IV COPD/Lung Disease
<input type="checkbox"/>	Suspected nocturnal seizures	<input type="checkbox"/>	Significant, persistent cardiac arrhythmia
<input type="checkbox"/>	Suspected narcolepsy	<input type="checkbox"/>	Neurodegenerative disorders or impairments
<input type="checkbox"/>	Central sleep apnea	<input type="checkbox"/>	History of stroke or myocardial infarction

Medications (please list all medications):

Epworth Sleepiness Scale:	
How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 imagine how they would have affected you.	
Use the following scale to choose the most appropriate number for each situation:	
0 = Would never doze or sleep	
1 = Slight chance	
2 = Moderate change of dozing or sleeping	
3 = High chance of dozing or sleeping	
Situation Chance of Dozing or Sleeping	
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a motor vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic while driving	
Total score	