Adult Sleep and Breathing Questionnaire Part 1

Date: _____

Patient 's Name: _____

Patient's Date of Birth: _____ Age: _____

Male _____ Female _____

Have you ever had a sleep test administered? _____yes _____no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? _____yes _____no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? _____yes _____no

Are you happy with your CPAP or Sleep Appliance? _____yes _____no

If you are not happy - why? _____

_____

How often do you get out of bed to use the restroom during the night? _____

Do you usually wake feeling tired and unrested? _____yes _____no

Do you habitually snore? _____yes _____no

Have you been diagnosted with Hypertension/High Blood Pressure? _____yes _____no

Do you often suffer from waking headaches? _____yes _____no

Do you regularly experience daytime drowsiness or fatigue? _____yes _____no

Do you have blocked nasal passages? _____yes _____no

Has anyone observed you stop breathing during your sleep? _____yes _____no

Do you ever wake up choking or gasping? _____yes _____no

Do you grind your teeth while sleeping? _____yes _____no

Is your neck circumference greater than 40 cm/ 15.75" ? _____yes _____no

Is your Body Mass Index (BMI) more than 35? _____yes _____no

BMI Formula / BMI = (your weight in pounds X 703)

_____ _____

(your height in inches X your height in inches

Adult Sleep and Breathing Questionnaire Part 2

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, iin 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 work out how they would have effected you. Use the following scale to choose the most appropriate number for each situation.

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting inactive in public place (like a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL SCORE	_____

Analyze Your Score

Interpretation:	
From 0-7	It is unlikely that you are abnormally sleepy
From 8-9	You have an average amount of daytime sleepiness
From 10-15	You may be excessively sleepy, depending on the situation. You may want to consider seeking medical attention
From 16-20	You are excessively sleep and should consider seeking medical attention

Adult Sleep and Breathing Questionnaire Part 3

Berlin Questionnaire© Sleep Apnea

Height (m) _____ Weight (kg) _____
Age _____ Male / Female

Category 1

1. Do you snore?
□ a. Yes
□ b. No
□ c. Don't know
If you answered 'yes':

2. You snoring is:
□ a. Slightly louder than breathing
□ b. As loud as talking
□ c. Louder than talking

3. How often do you snore?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ e. Rarely or never

4. Has your snoring ever bothered other people?
□ a. Yes
□ b. No
□ c. Don't know

5. Has anyone noticed that you stop breathing during your sleep?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ □ e. Rarely or never

Category 2

6. How often do you feel tired or fatigued after your sleep?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ e. Rarely or never

7. During your waking time, do you feel tired, fatigued or not up to par?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ e. Rarely or never

8. Have you ever nodded off or fallen asleep while driving a vehicle?
□ a. Yes
□ b. No
If you answered 'yes':

9. How often does this occur?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ e. Rarely or never

Category 3

10. Do you have high bloodpressure?
□ Yes
□ No
□ Don't know