apnea&breathing clinic

Patient Screening Form

Patient Information:

Patient Name:		**DOB:**	**Male/Female:**
Patient Address:	**City:**	**St:**	**Zip:**
Phone Number:	**Email:**		
Emergency Contact:	**Relationship:**	**Phone Number:**	
Referred by ☐ Website ☐ PCP/MD ☐ DDS ☐ Other:		**Preferred method of contact:** ☐ Phone ☐ Email ☐ Mail	
Medical Insurance Carrier:	**ID #:**	**Grp#:**	

Epworth Sleepiness Scale

Use the following scale to chose the **most appropriate number** for each situation:

0 = would **never** doze 1 = **slight chance** of dozing 2 = **moderate chance** of dozing 3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	**Chance of dozing (0-3)**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theatre 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**

0-9 Normal Daytime Sleepiness

10-12 Mild Daytime Sleepiness

12-15 Moderate Excessive Daytime Sleepiness

16-24 Severe Excessive Daytime Sleepiness

Signs & Symptoms:

Please check **all** that apply **Height:** _____ **Weight:** _____

☐ Loud Snoring	☐ High Blood Pressure	☐ Stroke	☐ Depression
☐ Insomnia	☐ Heart Disease	☐ Morning Headaches	☐ Restless Leg Syndrome
☐ Fatigue	☐ Diabetes Type II	☐ Clenching, Grinding	☐ Excessive Daytime Sleepiness

FAX Today: (918) 582-3903

Signature: _____ **Date:** _____

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