Epworth Sleepiness Scale

Name: _____ Date: _____

Age (Yrs): _____ Sex: ☐ Male ☐ Female

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 haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation, it is important that you answer each question as best you can:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

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 the traffic ……	_____
Total ……	_____

Affidavit of Intolerance to CPAP

I, _____, have attempted to use CPAP (Continuous Positive Air Pressure) to manage my sleep related breathing disorder (OSA - obstructive sleep apnea) and find it intolerable to use on a regular basis due to the following reason(s):

□ PAP is not effective in controlling my symptoms

□ I am unable to sleep with the CPAP equipment in place

□ Noise from the device disturbs my sleep or my bed partner's sleep

□ I cannot find a comfortable mask

□ The mask leaks

□ I develop sinus / throat / ear / lung infections

□ I am allergic to materials in the mask and head straps

□ Claustrophobia

□ I unconsciously remove the CPAP apparatus at night

□ Pressure from the mask and straps causes tissue breakdown

□ My job and/or lifestyle prevents this form of therapy (e.g. Active Army / National Guard)

□ Prior throat surgery makes CPAP intolerable

□ Other_____

Because of my inability to tolerate CPAP and my need to control the signs and symptoms of OSA, I wish to use an alternative method of treatment. This form of therapy is oral appliance therapy (OAT).

Signed:_____ Date:_____

Bed Partner/Witness Screening Questionnaire:
Obstructive Sleep Apnea

Name: _____

Person completing form: _____ Date: ___/____/____

Please answer the following questions as they pertain to your bed partner in the past month.

1. While sleeping, does your partner:

    Snore more than half the time? ..... ☐ Yes ☐ No ☐ Don't Know

    Always snore? ..... ☐ Yes ☐ No ☐ Don't Know

    Snore loudly? ..... ☐ Yes ☐ No ☐ Don't Know

    Have "heavy" or loud breathing? ..... ☐ Yes ☐ No ☐ Don't Know

    Have trouble breathing, or struggle to breathe? ..... ☐ Yes ☐ No ☐ Don't Know

2. Have you ever seen your partner stop breathing during the night? ..... ☐ Yes ☐ No ☐ Don't Know
3. Does your partner:

    Tend to breathe through the mouth during the day?..... ☐ Yes ☐ No ☐ Don't Know

    Have a dry mouth on waking up in the morning?..... ☐ Yes ☐ No ☐ Don't Know

    Occasionally wet the bed?..... ☐ Yes ☐ No ☐ Don't Know

4. Does your partner:

    Wake up feeling unrefreshed in the morning? ..... ☐ Yes ☐ No ☐ Don't Know

    Have a problem with sleepiness during the day? ..... ☐ Yes ☐ No ☐ Don't Know

5. Has a friend, coworker or supervisor commented that your partner appears sleepy during the day? ..... ☐ Yes ☐ No ☐ Don't Know

6. Is it hard to wake your partner up in the morning? ..... ☐ Yes ☐ No ☐ Don't Know

7. Does your partner wake up with headaches in the morning? ..... ☐ Yes ☐ No ☐ Don't Know

8. Is your partner overweight? ..... ☐ Yes ☐ No ☐ Don't Know

Questionnaire for Sleep Apnea and/or snoring

Name:_____ Sex: ☐ Female ☐ Male

Age:_____ Height: _____ Weight: _____

Do you have any difficulty falling asleep at night? ..... ☐ Yes ☐ No ☐ Often ☐ Sometimes

How many hours of sleep per night do you get? _____

About how many times per night do you wake up? _____

Have you been told you move around a lot while asleep? ..... ☐ Yes ☐ No ☐ Often ☐ Sometimes

Do you most often wake up feeling refreshed? ..... ☐ Yes ☐ No ☐ Often ☐ Sometimes

Do you have difficulty breathing through your nose? ..... ☐ Yes ☐ No ☐ Often ☐ Sometimes

Have you been told your breathing stops while asleep? ..... ☐ Yes ☐ No ☐ Often ☐ Sometimes

Have you had choking or shortness of breath sensations at night? ..... ☐ Yes ☐ No ☐ Often ☐ Sometimes

Do you wake up with a headache? ..... ☐ Yes ☐ No ☐ Often ☐ Sometimes

Have you had chronic sleepiness, fatigue, or weariness
that you cannot explain? ..... ☐ Yes ☐ No ☐ Often ☐ Sometimes

Have you felt your memory and/or intellect is impaired? ..... ☐ Yes ☐ No ☐ Often ☐ Sometimes

Will a small amount of alcohol give you a hang over? ..... ☐ Yes ☐ No ☐ Often ☐ Sometimes

How long have you been aware of your snoring? _____

Has it caused problems for relatives or friends? _____

Have you gained weight recently? ..... ☐ Yes ☐ No

About how much? _____

Have you seen other doctors about your snoring or sleep apnea? ..... ☐ Yes ☐ No

When: _____ Name of Doctor: _____

Have you had a sleep lab study? ..... ☐ Yes ☐ No

What professional advice or treatment have you received about your snoring or sleep apnea?

_____