ST. MARY'S
HEALTH CARE SYSTEM
Sleep Disorders Center

Patient Name _____

Epworth Sleepiness Scale

0-10 – Mild
10-16 – Moderate
16-24 – Severe

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling tired? This refers to your usual way of life in recent times even if you have done some of these things recently try to work out how they affect you. Use the following scale to choose 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

Sitting and reading	chance of dozing _____
Watching TV	chance of dozing _____
Sitting, inactive in a public place, For example, a theater or meeting	chance of dozing _____
As a passenger in a car for an hour without a break	chance of dozing _____
Lying down to rest in the afternoon	chance of dozing _____
Sitting and talking to someone	chance of dozing _____
Sitting quietly after lunch without alcohol	chance of dozing _____
In a car, while stopped for a few minutes in traffic	chance of dozing _____

Sleep Assessment Form

Height: _____ Weight: _____

1. Are you on home oxygen? Y N If yes, how many liters _____
2. Have you ever had a sleep study? Y N If yes, when _____
3. Have you ever had a CPAP study? Y N If yes, when _____
4. Do you use CPAP now? Y N If so, what pressure _____
5. How many hours of sleep do you usually get per night? _____
6. What time do you usually go to bed? _____
7. What time do you usually wake up? _____
8. Do you take naps? _____
9. How long does it take you to fall asleep at night? _____
10. How many times do you awaken per night? _____
11. If you wake up at night, do you go back to bed? _____
12. If you don't go back to bed do you watch TV, read, _____
    get on the computer, etc? _____
13. How many times do you go to the bathroom at night? _____
14. How do you feel after a typical night of sleep? _____
    Tired _____ Usually Sleepy _____ Good most of the time _____
15. How many cups of caffeinated beverages do you have a day? _____
    a. At what time of day? _____
16. How many alcoholic drinks do you have a day? _____
17. How many cigarettes/tobacco do you smoke a day? _____
18. If stopped, when did you stop?

St. Mary's Health Care System, Inc
Athens, GA
Sleep Disorders Center
Sleep Assessment Form

Patient Sticker

Sleep Disorders Center Patient Health Questionnaire

PATIENT HEALTH HISTORY

PLEASE CHECK ANY PROBLEM OR ILLNESS YOU HAVE OR HAVE HAD

Had	Currently Have		Had	Currently Have	
		Heart Disease			EDS
		Heart Attack			Muscle Cramps
		High Blood Pressure			Restless Legs
		Diabetes			Sinus Infections
		Depression			Fainting
		Head Trauma			Back Problems
		Stroke			Hearing Loss
		Seizures / Epilepsy			Tuberculosis
		COPD			Arthritis
		Emphysema			Asthma
		Snoring			Reflux
		Witnessed Apnea			Insomnia
		Morning Headaches			Latex Allergies

Medication and/or Other Allergies

	Current Medications:	Dosage	Frequency	Time Last Taken
1				
2				
3				
4				
5				
6				

Medication Allergies: _____

Signature_____

Form # 52012

St. Mary's Health Care System, Inc
Athens, GA
Sleep Disorders Center
Patient Health Questionnaire

ASM.X SCREENING - QUEST, SCREEN, CHECKLIST, EVALS

Patient Label