Name:		Gender: ☐ M ☐ F	DOB:
Address:	City:	State:	Zip:
Weight:	Height:	Neck Size:	
Phone:	Alt. Phone:	Email:	
PPO Medical Insurance Company (If insured has no PPO. Please circle one of the following: HMO / MEDICARE / CASH)		ID #:	Group #:

Have you ever been diagnosed with a sleep disorder? ☐ Yes ☐ No Night time oxygen use? ☐ Yes ☐ No

Are you currently using a CPAP machine? ☐ Yes ☐ No (If yes) Do you use it every night? ☐ Yes ☐ No

Answer **"Yes"** or **"No"** to the following questions (Circle Y or N):

Question		
Have you ever been told you stop breathing while asleep?	Y or N	8
Have you ever fallen asleep or nodded of while driving?	Y or N	6
Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	Y or N	6
Do you feel excessively sleepy during the day?	Y or N	4
Do you snore or have you ever been told that you snore?	Y or N	4
Have you had weight gain and found it difficult to lose?	Y or N	2
Have you taken medication for, or been diagnosed with high blood pressure?	Y or N	2
Do you kick or jerk your legs while sleeping?	Y or N	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Y or N	3
Do you wake up with headaches during the night or in the morning?	Y or N	3
Do you have trouble falling asleep?	Y or N	4
Do you have trouble staying asleep once you fall asleep?	Y or N	4
Score and Risk Factor – on right, add total pts. That you have circled "Y" and circle Risk Level (Below)	Score Total =	

Low	Moderate	High	Severe
0-7	8-11	12-15	16+

DX:

☐ Hypertension	☐ Heart Failure	☐ Stroke	☐ Obesity
☐ Nocturia	☐ Depression	☐ Exessive Daytime Sleeping	☐ Diabetes
☐ Neck Size > 15 (Women)	☐ Neck Size >17 (Men)	☐ OSA	☐ Cancer

Rx:

☐ Two-night Home Sleep Study or ---- -night (Indicate number of days 1-3) ☐ Sleep Specialist Consultation

Notes:

Medical Practice /Group:			Medical Professional Name:	
Physical Address:				
Phone:	Faxe:		Email:	
State License #:			NPI #:	
Dr. Signature:	Date:			Office Contact:

This questionnaire was developed based upon the published findings of the American Academy of Sleep Medicine (AASM). The purpose of this questionnaire is to aid a qualified medical professional in identifying possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.

Phone: Office Use: A/E **Fax:**

If Applicable, Patient to Please Provide ID & PPO Medical Insurance Card to Front Desk for Copy (Front + Back)