Date: _____

Name of Physician: _____

Physician's Address: _____

Have you been evaluated by an Ear Nose Throat (ENT) specialist? □Yes □No

Have you had your tonsils removed? □ Yes □ No

Have you had your adenoids removed? □Yes □No

Do you snore? □ Yes □No If yes how frequently? _____

Can you hear teeth grinding while sleeping? □ Yes □ No

Have you ever had a sleep evaluation or overnight sleep study (polysomnography)?

□Yes □No

Were you ever diagnosed with apnea? □Yes □No

If yes, what treatment did you receive? _____

_____

Are you still utilizing treatment? □Yes □ No

Has your weight changed significantly recently (gained weight or lost weight)?

□Yes □No

If available, please supply a copy of your previous sleep study report.

THE EPWORTH SLEEPINESS SCALE

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 have not 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:

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 a public place (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 Scale	