# Sleep Assessment Form

This is a screening form to assess the need to complete a sleep study to determine if you have a sleep disorder. As you likely know, the quality of your sleep can have a major affect on your overall quality of life, especially your cardiovascular health. Long term sleep apnea can negatively affect your well-being, can lead to heart arrhythmias, as well as increase your chance for diabetes and stroke.

Sleep disorders can be treated effectively when addressed in a timely manner. If your assessment indicates the need to complete an official sleep study, the team at Sleep Better Lexington is here to help guide you in the right direction. Just give us a call at (859) 721-2072.

***Epworth Sleepiness Scale:***

Using the following numbered scale, how likely are you to doze off while doing the following activities?

0 = Never 1 = Slight 2 = Moderate 3 = High (Circle one of the following numbers)

## Section 1

1. Being a passenger in a motor vehicle for an hour or more : ..... 0 1 2 3
2. Sitting and talking to someone : ..... 0 1 2 3
3. Sitting and reading : ..... 0 1 2 3
4. Watching TV : ..... 0 1 2 3
5. Sitting inactive in a public place : ..... 0 1 2 3
6. Lying down to rest in the afternoon : ..... 0 1 2 3
7. Sitting quietly after lunch without alcohol : ..... 0 1 2 3
8. In a car, while stopped for a few minutes in traffic : ..... 0 1 2 3

Total : _____

Score **1 point** for this section if the **total** is **8 or more**. (*This section cannot exceed 1 point.*)

## Section 2

1. Have you been told that you snore? ..... Yes ___ No ___
2. Does your family have a history of premature death in sleep? ..... Yes ___ No ___
3. Do you have diabetes? ..... Yes ___ No ___
4. Have you ever been told you have coronary artery disease? ..... Yes ___ No ___
5. Do you have high blood pressure? ..... Yes ___ No ___
6. Have you ever experienced irregular heart rhythms? ..... Yes ___ No ___

Total : _____

Score **1 point** for each **yes** answer from this section.

## Section 3

1. Have you ever been diagnosed with sleep apnea? ..... Yes ___ No ___
2. Do you awaken from sleep with chest pain or shortness of breath? ..... Yes ___ No ___
3. Has anyone said that you seem to stop breathing while sleeping? ..... Yes ___ No ___
4. Is your neck size larger than 15" (Female) or 16.5'' (Male)? ..... Yes ___ No ___

Neck Size: _____

5. Have you ever had a stroke? ..... Yes ___ No ___
6. Have you ever been told you have congestive heart failure? ..... Yes ___ No ___
7. Do you have, or did you ever have atrial fibrillation? ..... Yes ___ No ___
8. Are you currently taking pain meds? ..... Yes ___ No ___

Total : _____

Grand Total : _____

Score **2 points** for each **yes** answer in this section.

A total score of **3 or more** for the **1st & 2nd** sections indicates a sleep test is needed.
A total score of **3 or more** + **"Snoring"** indicates a sleep test is needed.
A total of **4 or more** for the **1st, 2nd & 3rd** sections indicates a sleep test is needed.
If patient reports a history of **Lung Disease** or **CHF**, refer out for a lab-based study.