

SLEEP BREATHING DISORDER SCREENING

Name (Last, First): _____ Date of Birth: _____ Today's Date: _____

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? 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

Previous therapy - none, cpap, surgery , other _____ (circle)*

Date

SITUATION	BEFORE THERAPY	AFTER THERAPY*
Sitting and reading	_____	_____
Watching Television	_____	_____
Sitting inactive in a public place (i.e. theater)	_____	_____
As a car passenger for an hour without a break	_____	_____
Lying down to rest in the afternoon	_____	_____
Sitting and talking to someone	_____	_____
Sitting quietly after lunch without alcohol	_____	_____
In a car, while stopping for a few minutes in traffic	_____	_____
TOTAL SCORE	_____	_____

A score of 6 or greater indicates the possibility of sleep disordered breathing.

*Fill in only if you have had previous therapy

THORNTON SNORING SCALE

Snoring has a significant effect on the quality of life for many people. Snoring can affect the person snoring and those around him/her, both physically and emotionally. Use the following scale to choose the most appropriate number for each situation. (Go to question #4 if you have no bed partner.)

0 = Never

1 = Infrequently (1 night per week)

2 = Frequently (2-3 nights per week)

3 = Most of the time (4 or more nights per week)

Previous therapy - none, cpap, surgery , other _____ (circle)*

	BEFORE THERAPY	AFTER THERAPY*
My snoring affects my relationship with my partner	_____	_____
My snoring causes my partner to be irritable or tired	_____	_____
My snoring required us to sleep in separate rooms	_____	_____
My snoring is loud	_____	_____
My snoring affects people when I am sleeping away from home (i.e. hotel, camping, etc.)	_____	_____
TOTAL SCORE	_____	_____

A score of 5 or greater indicates your snoring may be significantly affecting your quality of life

*Fill in only if you have had previous therapy

Office Use ONLY:

Neck Size: _____ Waist Size: _____ Height: _____ Weight: _____ BMI: _____ Referral: _____