Park Lakes
Family Medicine, P.A.

Aesthetics, Wound Care & Hyperbaric Medicine

Sleep Evaluation

Date_____ Name_____DOB_____

Ht_____ Wt_____ Neck Circumference_____ BMI_____

Please check Yes or No to the following:

- "Active" sleep-patient moves around/tosses all night long Yes___ No___
- BMI>**35** with the **inability to lie flat in bed** Yes___ No___
- Sleep deprived spouse or partner Yes___ No___
- Gastroesophageal reflux Yes___ No___
- Irregular breathing Yes___ No___
- **"habitual"** snoring Yes___ No___
- Excessively tired throughout the day (EDS) Yes___ No___
- Morning Headaches Yes___ No___
- Difficulty concentrating Yes___ No___
- Large neck circumference= 17in. male /16in. female Yes___ No___
- Frequent urination during the night Yes___ No___
- PTSD-Post traumatic stress disorder/Anxiety Yes___ No___
- Pulmonary disease (Asthma,COPD) Yes___ No___
- Sleep disordered breathing Yes___ No___
- Wheezing, coughing and dyspnea during sleep Yes___ No___

Epworth Sleepiness Scale

Chance of Dozing: 0=never 1=slight 2=moderate 3=high/always

Sitting and reading---------- ____
Watching TV---------- ____
Sitting inactive in a public place---------- ____
Passenger in a car for an hour---------- ____
Lying down to rest in the afternoon----------____
Sitting and talking to someone---------- ____
Sitting quietly after lunch without alcohol---------- ____
In a car while stopped for a few minutes in traffic----____

Score:

0-10=Normal 10-12=Borderline 12-24=Abnormal Total Score:___

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