Phone: (817) 358-5800

Patient Name: ____________________________ Date of Birth: ____/____/____

A good night's sleep is paramount to your health.
Please take a moment to answer the following questions:

Do you have high blood pressure? Yes / No / Don't know (circle one) Weight: ____________

Do you have diabetes? Yes / No / Don't know (circle one) Height: ____________

Have you ever nodded off or fallen asleep at the wheel? Yes / No (circle one) BMI: ____________

Do you snore? Yes / No (circle one)

Does your snoring bother other people? Yes / No / Not applicable (circle one)

Do you have frequent headaches? Yes / No (circle one) Neck circumference: _______

Epworth Sleepiness Scale (ESS)

Use this scale to choose the most appropriate number for each situation:
0 = would never doze 2 = moderate chance of dozing
1 = slight chance of dozing 3 = high chance of dozing
It is important that you circle a number (0 to 3) on each of the questions.

Situation	Chance of dozing (0-3)			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place—for example, a theater or meeting	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3

Total Score:_______

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