EXPERT SLEEP MEDICINE

Expert Sleep Quiz

Symptoms (Please circle all that apply) **Height____ Weight_____**

Sleepiness	Insomnia	Movement while asleep	Restless Sleep
Multiple awakenings	Sleep walking	Fatigue	Mood disorder
Sleep talking	Snoring	Poor Brain function	Acting out dreams
Witnessed Apnea	Restless legs	Abnormal dreams	Are you on CPAP/BiPAP

Sleep Hygiene/Habits

Do you awaken short of breath at night?	❑Yes ❑No
Has anyone told you that you stop breathing at night?	❑Yes ❑No
Do you awaken feeling tired or fatigued?	❑Yes ❑No
Do you have excessive daytime sleepiness?	❑Yes ❑No
Does work intrude on your sleep pattern or schedule?	❑Yes ❑No
Does leg movement or pain awaken you at night?	❑Yes ❑No
Do you sleep talk or walk?	❑Yes ❑No
Do you “act out your dreams?	❑Yes ❑No
Do you have trouble going to and staying asleep?	❑Yes ❑No
Do you get less than 7 hours of sleep every night?	❑Yes ❑No
When you are going to sleep or awakening, are you temporarily parallized?	❑Yes ❑No
Do you ever feel weak when expressing a strong emotion (fear, laughter?)	❑Yes ❑No
If you wake up at night, does it take a long time to fall asleep again?	❑Yes ❑No
Do you feel the need to nap	❑YES ❑NO
Do you have the different sleep schedule during the week due to work	❑YES ❑NO
Do you sleep longer on the weekend	❑YES ❑NO
Does your work schedule interfer with your sleep	❑YES ❑NO
Do you work when your body clock would prefer that you sleep	❑YES ❑NO

What was your Epworth Sleepiness Scale (> 10 is abnormal, see back)_____

What is your STOPBANG score (>3 is abnormal, see back)_____

Expertsleep.com phone (502)963-0487 fax (502) 963-0488

STOP BANG Questionnaire

1. **Snoring**	Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	Yes No
2. **Tired**	Do you often feel tired, fatigued, or sleepy during daytime?	Yes No
3. **Observed**	Has anyone observed you stop breathing during your sleep?	Yes No
4. **Blood pressure**	Do you have or are you being treated for high blood pressure?	Yes No
5. **BMI**	BMI more than 35 kg/m2? **	Yes No
6. **Age**	Age over 50 yr old?	Yes No
7. **Neck circumference**	Neck circumference greater than 15 in (female) 17 in (male)?	Yes No
8. **Gender**	Gender male?	Yes No

High risk of OSA: answering yes to three or more items
Low risk of OSA: answering yes to less than three items
**** to find BMI go to expertsleep.com>obesity>BMI**

Total Yes answers _____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in these situations? 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:

Situation	**Chance of Dozing**	**Scale**
1. Sitting and Reading	0 1 2 3	0 = would never doze
2. Watching TV	0 1 2 3	1 = slight chance of dozing
3. Sitting inactive in a public place	0 1 2 3	2 = moderate chance of dozing
4. As a passenger in a car for an hour without a break	0 1 2 3	3 = high chance of dozing
5. Lying down to rest in the afternoon when circumstances permit	0 1 2 3	
6. Sitting and talking to someone	0 1 2 3	
7. Sitting quietly after lunch (without alcoholic beverage)	0 1 2 3	
8. In a car while stopped for a few minutes in traffic	0 1 2 3	

Epworth Sleepiness Total

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