SLEEP BETTER
MIDWEST

Date: _____

Patient Name: _____Date of Birth: _____

Gender: Male/Female Home Phone: _____Cell: _____

Address: _____

City: _____State: _____Zip: _____

Primary Care Physician: _____Phone Number: _____

Medical Insurance Provider: _____ Secondary Ins: _____

Do you suffer from the following?

Obstructive Sleep Apnea: ☐ Yes ☐ No

Loud Snoring: ☐ Yes ☐ No

High Blood Pressure: ☐ Yes ☐ No

Heart Disease: ☐ Yes ☐ No

Nighttime Urination: ☐ Yes ☐ No

Morning Headache: ☐ Yes ☐ No

Restless Leg Syndrome: ☐ Yes ☐ No

Diabetes: ☐ Yes ☐ No

Thyroid Disease: ☐ Yes ☐ No

Insomnia: ☐ Yes ☐ No

Depression: ☐ Yes ☐ No

COPD: ☐ Yes ☐ No

Stroke: ☐ Yes ☐ No

Epworth Sleepiness Questionnaire

Denote a number with the chance of dozing during the following activities:

0 = Never Doze 1 = Slight Chance 2= Moderate Chance 3 = High Chance

Sitting and Reading	**0**	**1**	**2**	**3**
Sitting quietly in a public place	**0**	**1**	**2**	**3**
Watching TV	**0**	**1**	**2**	**3**
Sitting quietly after lunch w/o alcohol	**0**	**1**	**2**	**3**
As a passenger in a car not stopping	**0**	**1**	**2**	**3**
In a car while stopped in traffic for a few minutes	**0**	**1**	**2**	**3**
Laying down to rest in the Afternoon	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**

Total _____

Please check (✓) the correct response to each question:

1. **Do You Snore?**
   - ☐ **Yes**
   - ☐ **No**
   - ☐ **I Don't know**
2. ***IF* You Snore: Your Snoring is**
   - ☐ **Slightly Louder than Breathing**
   - ☐ **As Loud as Talking**
   - ☐ **Louder than Talking**
   - ☐ **Louder than Talking – Can be heard in adjacent rooms**
3. **How often do you Snore?**
   - ☐ **Nearly Everyday**
   - ☐ **3-4 time a week**
   - ☐ **1-2 times a week**
   - ☐ **Never or nearly Never**
4. **Has your Snoring ever bothered people?**
   - ☐ **Yes**
   - ☐ **No**
   - ☐ **I Don't know**
5. **Has anyone ever noticed that you quit breathing in your sleep?**
   - ☐ **Nearly Everyday**
   - ☐ **3-4 time a week**
   - ☐ **1-2 times a week**
   - ☐ **1-2 times a month**
   - ☐ **Never or nearly Never**
6. **How often do you feel fatigued or tired after you sleep?**
   - ☐ **Nearly Everyday**
   - ☐ **3-4 time a week**
   - ☐ **1-2 times a week**
   - ☐ **1-2 times a month**
   - ☐ **Never or nearly Never**
7. **During your waking time, do you feel tired, fatigued, or Not up to Par?**
   - ☐ **Nearly Everyday**
   - ☐ **3-4 time a week**
   - ☐ **1-2 times a week**
   - ☐ **1-2 times a month**
   - ☐ **Never or nearly Never**
8. **Have you ever fallen asleep or nodded off while driving a vehicle?**
   - ☐ **Yes**
   - ☐ **No**
9. **If YES, then How often does this Happen?**
   - ☐ **Nearly Everyday**
   - ☐ **3-4 time a week**
   - ☐ **1-2 times a week**
   - ☐ **1-2 times a month**
   - ☐ **Never or nearly Never**
10. **Do You have High Blood Pressure?**
    - ☐ **Yes**
    - ☐ **No**

Age:_____ **Bedtime:**_____

Height:_____

Weight:_____

Neck Size:_____

Waist:_____

Hip:_____