SomnoMed Sleep Health Questionnaire

CURRENT THERAPIES

Have you attempted CPAP therapy?	Y or N
- If yes, are you able to use it at least 5 nights a week (4 or more hours per night)?	Y or N
Have you undergone any surgical attempts to correct your sleep apnea?	Y or N
Would you prefer an oral device?	Y or N

Have you tried any of the following conservative methods of improving your sleep breathing? (Please check)

❑ Weight loss ❑ Positional therapy: Avoiding sleeping on your back during sleep (the supine position)

❑ Abstaining from the use of alcohol and/or sedatives before bedtime

PATIENT SLEEPINESS SCALE

STEP 1 Answer "Yes" or "No" for the following questions (circle Y or N). If you answer "Yes," also circle the corresponding points in the column to the right.

STEP 2 Total the points that you circled in the right column and record score in the space below.

Have you ever been told you stop breathing while asleep?	Y or N	8
Have you ever fallen alseep or nodded off while driving?	Y or N	6
Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	Y or N	6
Do you feel excessively sleepy during the day?	Y or N	4
Do you snore or have you ever been told that you snore?	Y or N	4
Have you had weight gain and found it difficult to lose?	Y or N	2
Have you taken medication for, or been diagnosed with high blood pressure?	Y or N	2
Do you kick or jerk your legs while sleeping?	Y or N	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Y or N	3
Do you wake up with headaches during the night or in the morning?	Y or N	3
Do you have trouble falling alseep?	Y or N	4
Do you have trouble staying asleep once you fall asleep?	Y or N	4
	SCORE	

Risk Level	Low	Moderate	High	Severe+
Score	0-7	8-11	12-15	16+

SIGNS & SYMPTOMS

❑ Hypertension	❑ Snoring	❑ Diabetes	❑ Depression
❑ Grind Teeth	❑ Acid Reflex	❑ Stroke/Heart Disease	❑ Unrefreshed Sleep
❑ Family History of Snoring or Sleep Apnea			