NAME:_____ **BIRTHDATE:**_____**DATE:**_____

Have you ever been given a CPAP device?	YES	NO
If yes, do you use it every night?	YES	NO
Are you comfortable with your CPAP and satisfied with it's use?	YES	NO

IF you answered **YES to ALL THREE** questions, you are done, **THANK YOU!**
IF you answered **NO to ANY** of the questions above, please continue to **PART 1.**

PART 1: EPWORTH SLEEPINESS SCALE:

How likely are you to dose off while doing the following activities? Please use following scale: 0-never; 1-Slight; 2-Moderate; 3-High.

Being a passenger is a motor vehicle for an hour or more……	0	1	2	3	
Sitting and talking to someone……	0	1	2	3	
Sitting and reading……	0	1	2	3	Part 1
Watching TV ……	0	1	2	3	Total =
Sitting Inactive in a public place……	0	1	2	3	
Laying down to rest in the afternoon……	0	1	2	3	
Sitting quietly after lunch without alcohol……	0	1	2	3	
In a car, while stopped for few minutes in traffic……	0	1	2	3	

TOTAL*_____

*Score total of 8 or more= 1 diagnostic point

PART 2: Every Yes = 1 Diagnositc Point.

Have you ever been told you snore?	YES	NO	
Do you wake up choking or gasping or startling yourself?	YES	NO	
Do you have high blood pressure?	YES	NO	Part 2
Do you have diabetes?	YES	NO	Total =
Have you ever experienced an irregular heart rhythm?	YES	NO	

PART 3: Every Yes = 1 Diagnostic Point.

Does snoring cause any problems at home?	YES	NO	Part 3
If yes, would you like to fix that?	YES	NO	Total =

PART 4: TO BE COMPLETED BY STAFF

Neck size:_____(IF, Females >15, Males >16.5 = 1 Diagnostic point) Part 4
Height:_____Weight_____BMI_____ (BMI > 30 = 1 Diagnostic point) Total =
Mallampati_____(Class III or IV = 1 Diagnostic point)
Scalloped Tongue_____(YES = 1 Diagnostic point)

TOTAL OVERALL SCORE:_____
SCHEDULE PCP/TELEMEDICINE Visit:_____

PATIENT SIGNATURE:_____DATE:_____

DOCTOR SIGNATURE:_____DATE:_____

NAME:_____**BIRTHDATE:**_____**DATE:**_____

SLEEP APNEA EVALUATION

THIS SECTION TO BE COMPLETED BY STAFF

1-Large "Scalloped" Tongue:	YES		NO	
2-Bruxism:	YES		NO	
3-Class II Molar >3mm:	YES		NO	
4-Dentin Exposure:	YES		NO	
5-Class V Erosion:	YES		NO	
6-High Arched Palate:	YES		NO	
7-Tapered Jaws:	YES		NO	
8-Xerostomia:	YES		NO	
9-Tonsil Classification:	I	II	III	IV
10-Mallampati Classification:	I	II	III	IV

Additional:_____

MEDICAL CONDITIONS/COMORBIDITIES

THIS SECTION TO BE COMPLETED BY PATIENT

1-High Blood Pressure?	YES	NO
2-Stroke or any Heart Conditions?	YES	NO
3-GERD(Acid Reflux)?	YES	NO
4-Anti-Depressants?	YES	NO
5-Obesity?	YES	NO
6-Daytime Sleepiness?	YES	NO
7-Diabetes?	YES	NO

Additional:_____