

## Weisfogel Sleep Disorder Assessment

This form evaluates the need for you to have a user-friendly home sleep test. The home sleep test will determine if you have a sleep disorder. Sleep disorders negatively affect your well-being, especially your cardiovascular health. Sleep disorders can be treated effectively.

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Physician Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

1. Have you ever been given a CPAP device?..... Yes \_\_\_ No \_\_\_
2. If you have been given any form of CPAP, do you use it nightly?..... Yes \_\_\_ No \_\_\_
3. Are you comfortable with your CPAP and satisfied with its use?..... Yes \_\_\_ No \_\_\_

***If the answer is "Yes" to all three questions, YOU ARE DONE!***

If your answer is "No" to any of the above questions, please continue to **Part 1**.

### Part 1 Epworth Sleepiness Scale

How likely are you to doze off while doing the following activities? Please use the following scale:  
0 = never, 1 = slight, 2 = moderate, 3 = high. Circle one of the following numbers:

1. Being a passenger in a motor vehicle for an hour or more..... 0 1 2 3
2. Sitting and talking to someone..... 0 1 2 3
3. Sitting and reading..... 0 1 2 3
4. Watching TV..... 0 1 2 3
5. Sitting inactive in a public place..... 0 1 2 3
6. Lying down to rest in the afternoon..... 0 1 2 3
7. Sitting quietly after lunch without alcohol..... 0 1 2 3
8. In a car, while stopped for a few minutes in traffic..... 0 1 2 3

### Part 2

1. Have you been told that you snore?..... Yes \_\_\_ No \_\_\_
2. Does your family have a history of premature death in sleep?..... Yes \_\_\_ No \_\_\_
3. Do you have diabetes?..... Yes \_\_\_ No \_\_\_
4. Have you ever been told you have coronary artery disease?..... Yes \_\_\_ No \_\_\_
5. Do you have high blood pressure?..... Yes \_\_\_ No \_\_\_
6. Have you ever experienced irregular heart rhythms?..... Yes \_\_\_ No \_\_\_

### Part 3

1. Have you ever been diagnosed with sleep apnea?..... Yes \_\_\_ No \_\_\_
2. Do you awaken from sleep with chest pain or shortness of breath? Yes \_\_\_ No \_\_\_
3. Has anyone said that you seem to stop breathing while sleeping?.. Yes \_\_\_ No \_\_\_
4. Is your neck size larger than 15" (female) or 16.5" (male)..... Yes \_\_\_ No \_\_\_
5. Have you ever had a stroke?..... Yes \_\_\_ No \_\_\_
6. Have you ever been told you have congestive heart failure?..... Yes \_\_\_ No \_\_\_
7. Do you have or did you ever have atrial fibrillation?..... Yes \_\_\_ No \_\_\_
8. Are you currently taking pain meds?..... Yes \_\_\_ No \_\_\_

Actual Neck Size

Dentist's Signature: _____ Date: _____	SA Score _____ <input type="checkbox"/> Negative <input type="checkbox"/> Positive
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