COMPLETE**SLEEP**RELIEF

203 Telluride St. Ste. 720 Brighton, CO 80601
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Patient's Name: ____________________ DOB: ___________

Height:______ Weight: ______ Neck Size: ______

Have you been diagnosed or tested for any of the following conditions? Yes=Y or No=N

High Blood Pressure? ____________

Heart Disease? __________

Diabetes? _________

Lung Disease? _________

Insomnia? _________

Narcolepsy? _________

Sleeping Medications? _________

Stroke? _________

Depression? _________

Sleep Apnea? _________

Nasal oxygen Use? _________

Restless Leg Syndrome? _______

Morning Headaches? __________

Pain Medications? _________

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations in contrast to just felling tired? 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 mare the most appropriate box for each situation.

0= would never doze, 1= slight chance of dozing, 2= moderate chance of dozing, 3= high chance of dozing

*Sitting and reading- __________

* Watching T.V ________

*Sitting, inactive, in a public place (theater, meeting, etc.)- _________

*Sitting and talking to someone-___________

*As a passenger in a car for an hour without a break- _________

* Lying down to rest in the afternoon- __________

*Sitting quietly after lunch without alcohol- __________

* In a car, while stopped for a few minutes in traffic- ___________

NEVER=0, RARELY=1, SOMETIMES=2, FREQUENTLY=3

*On average in the past month, how often have you snored or been told you snore? __________

*Do you wake up choking or gasping? __________

*Have you been told you stop breathing in your sleep? _________

*Do you have problems keeping your legs still at night or need to move them to feel comfortable? __________