Tania Baker DDS

THERAPY FOR OBSTRUCTIVE SLEEP APNEA

Name: ______________________________________

Age: ________ Weight ________ Neck Size ________

Primary Care Physician: ______________________________

Contact information: ______________________________

Insurance information: ______________________________

Epworth Sleepiness Scale

Sitting and Reading	________
Watching TV	________
Sitting, inactive, in a public place	________
As a passenger in a car for one hour	________
Lying down to rest in the afternoon	________
Sitting quietly after lunch without alcohol	________
Sitting and talking to someone	________
In a car. while stopped for a few minutes in traffic	________

Have you ever been diagnosed or treated for:

High Blood Pressure?	YES	NO	4
Has anyone told you that you snore?	YES	NO	4
Have you had weight gain and find it difficult lose?	YES	NO	4
Do you wake up with headaches in the morning?	YES	NO	3
Do you have trouble falling asleep?	YES	NO	4
Do you have trouble staying asleep?	YES	NO	7
Do you wake up at night to go to the bathroom?	YES	NO	4
Do you awaken suddenly with shortness of breath?	YES	NO	6

Low 0-7 Moderate 8-11 Severe 12+ Score: ______

Answer Scale:

Use the scale below to mark the most appropriate box for each situation listed on the left.

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

Answer Key:

1-6 = you're getting enough sleep
4-8= you tend to be sleepy during daytime.
9-15= Seek the advice of a sleep specialist without delay.

WHAT DOES THE EPWORTH TEST TELL ME?

A Sleep Test is the only way to confirm if you are suffering from Snoring or Sleep Apnea. By completing the Epworth Sleep Test, Dr. Baker can determine which testing option, home or in-lab, would be best for you.

If left untreated, snoring and Sleep Apnea can put you at increased risk to develop serious health problem including high blood pressure, stroke, congestive heart failure and coronary artery disease.

I hereby consent to the disclosure of my response to the Sleep Apnea Questionnaire for the purpose of assisting in the diagnosis and treatment of a potential sleep disorder. I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent such disclosure for the permitted uses, including, but not limited to, disclosures via fax. I fully understand and accept the terms to this consent.

Name: ______________________ Signature: ______________________ Date: __________