Physician's Sleep Study Questionnaire

Participant: _____ **MPI ID:** _____

Patient: _____ **Date:** _____

Age: yrs. **Wt**: lbs. **Gender:** ☐ Male ☐ Female **Ht:** ft. in. **Neck Size:** in.

History of:

Snoring Frequency: ☐ Never ☐ Occasionally ☐ Frequently ☐ Always

Loudness: (Use a scale from 1 to 10, 1 = very quiet to 10 = very loud) _____

Hypertension: ☐ Yes ☐ No

Witnessed apneas, choking or gasping: ☐ Yes ☐ No

Average number of hours of sleep per night: _____

The Epworth Sleepiness Scale

In the patient's typical daily life, how likely is s/he to doze off or fall asleep in the following situations (in contrast to just feeling tired)? If s/he has not been in these situations recently, have his/her imagine how the following situations would effect him/her.

Use the following scale to choose the most appropriate number for the situation:

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

Situation:

_____ Sitting and reading

_____ Watching Television

_____ Sitting, inactive, in a public place (theatre, meeting, etc.)

_____ As a passenger in a car for an hour without a break

_____ Lying down to rest in the afternoon when circumstances permit

_____ Sitting and talking to someone

_____ In a car, while stopped for a few minutes in traffic

_____ Sitting quietly after lunch without alcohol

_____ Driving a car or truck for two (2) hours or more

Type of Study Requested:

☐ 1. Full attended sleep study, CPAP if necessary, for suspected severe sleep apnea, or for unknown cause of sleepiness.

☐ 2. Other Study: _____

Physician's Name: _____ **License #** _____

Address: _____

Telephone: _____ **FAX** _____

_____ ☐

Physician's Signature **Date**

Return completed form to the Medical Review Department:
MPIHP, P.O. Box 1999, Studio City, California 91614-0999