

# FAMILY SLEEP DIAGNOSTICS

SAVING LIVES AND MARRIAGES

## SLEEP STUDY SELF-REFERRAL

Name \_\_\_\_\_ DOB \_\_\_\_\_ Sex  M  F

Address \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_  Home  Cell  Work Best Time to Call \_\_\_\_\_

**Medical Insurance Information:** I have Health Insurance  Yes  No Medicare  Yes  No

Company Name \_\_\_\_\_ Grp# \_\_\_\_\_ ID# \_\_\_\_\_

### Risk Factors:

- |  |                                      |                                     |  |
|--|--------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Coronary Artery Disease     | <input type="checkbox"/> Impotence   | <input type="checkbox"/> Stroke     | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Frequent Urination at Night | <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Disease       |
| <input type="checkbox"/> GERD                        | <input type="checkbox"/> Arrhythmias | <input type="checkbox"/> Obesity    | <input type="checkbox"/> Atrial Fibrillation |

*The above conditions are considered co-morbid with OSA. HBP & Obesity are risk factors independent of OSA.*

### Do you know your numbers?

Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_ Neck Circumference: \_\_\_\_\_ Inches

Blood Sugar/A1C: \_\_\_\_\_ Cholesterol Levels: LDL \_\_\_\_\_ HDL \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

### Snoring:

Score

- |   |                              |                             |                                     |               |
|---|------------------------------|-----------------------------|-------------------------------------|---------------|
| 1. Do you snore often (3 or more nights a week)?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | _____ Yes = 1 |
| 2. Is your snoring loud enough to be heard through a closed door?                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | _____ Yes = 1 |
| 3. Have you noticed or been told that, during sleep, you frequently stop breathing or gasp for air? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | _____ Yes = 1 |
| 4. Has your snoring / breathing during sleep bothered others/yourself?                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | _____ Yes = 1 |

(Sum of "Yes" checked above) **Total Score** \_\_\_\_\_

*A score of  $\geq 2$  coupled with hypertension, a BMI of  $> 30$ , OR and Epworth Score (from below) of  $> 9$  indicates high probability of OSA.*

### Epworth Sleepiness Scale:

Never would  
Doze Off

Slight Chance  
of Dozing

Moderate  
Chance of Dozing

High Chance  
of Dozing

### Do you get sleepy or doze off...

- |   |                            |                            |                            |                            |
|---|----------------------------|----------------------------|----------------------------|----------------------------|
| While sitting and reading?                        | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| While watching TV?                                | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| While sitting or inactive in a public place?      | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| As a passenger in a car for an hour, w/o a break? | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| Lying down to rest in the afternoon?              | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| Sitting and talking to someone?                   | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| Sitting quietly after lunch, w/o alcohol?         | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| While stopped a few minutes for a traffic light?  | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |

*A score of  $\geq 10$  OR a score of 8 or 9 along with any additional Risk Factor (from above) indicates high probability of OSA. **Total Score** \_\_\_\_\_*

**Fax this completed Form to 1-800-816-1477 and a Sleep Specialist will call to discuss your sleep issues.**