# Sleep Observer Scale Patient Form

Please fill out this form, and then print and bring it with you, mail, or fax it to the office of Dr. Hodgins at: (407) 647-0139.
You can also request an appointment through the Contact Us section of our website.

The following questions relate to the behavior that you have observed in the patient is while he/she is asleep. Use the following scale to choose the most appropriate number for each situation.

0=Never
1=Infrequently (1 night per week)
2=Frequently (2-3 nights per week)
3=Most of the time (4 or more nights per week)

_____ Loud, irritating snoring

_____ Choking or gasping for air

_____ Pauses in breathing

_____ Twitching / kicking of arms or legs

_____ Snoring requiring separate bedrooms

_____ Falling asleep inappropriately (example: while driving or at meetings)

**TOTAL SCORE:** _____

A score of 5 or greater indicates symptoms which are affecting the health, safety, or quality of life of the observed person. Please contact our office to schedule an appointment.

Patient Name: _____ Date of Birth:_____

Address: _____ City: _____ ST:_____ Zip Code:_____

Phone: _____ Email: _____

# Epworth Sleepiness Scale

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? 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 choose the most appropriate number or each situation.

**0 = WOULD NEVER DOZE**
**1 = SLIGHT CHANCE OF DOZING**
**2 = MODERATE CHANCE OF DOZING**
**3 = HIGH CHANCE OF DOZING**

| SITUATION | CHANCE OF DOZING |
|---|---|
| Sitting and Reading | |
| Watching TV | |
| Sitting inactive in a public place (i.e., in a theatre) | |
| As a car passenger for an hour without a break | |
| Lying down to rest in the afternoon | |
| Sitting and talking to someone | |
| Sitting quietly after lunch (without alcohol) | |
| In a car, while stopping for a few minutes in traffic | |

TOTAL SCORE: _____

- Have you had a sleep study? _____
- Do you own a CPAP? _____
- If so, do you use it nightly? _____

SIGNATURE: _____ NAME:_____ DATE:_____