**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Weight:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Height:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THE EPWORTH SLEEPINESS SCALE (ESS)**

How likely are you to doze off or fall asleep in the following situations:

**Score:**

0-10 = Normal Range

10-12 Borderline

12-24 Abnormal

0 =**No** chance

1=**Slight** chance

2=**Moderate** chance

3=**High** chance

**Sitting quietly reading a book or magazine**

**Watching TV**

**Sitting in a public place (ex. Movie theatre or Meeting)**

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

**Lying down to rest in the afternoon**

**Sitting and talking to someone**

**Sitting quietly after a lunch without alcohol**

**In a car while stopped for a few minutes in traffic**

**TOTAL**

**Symptoms/Complaints**: Have you experienced any of the following? Please check all that apply.

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_\_ Loud Snoring/Snoring | \_\_\_\_\_\_ High Blood Pressure | \_\_\_\_\_\_ Awakens w/Headache |
| \_\_\_\_\_\_ Witnessed Apnea | \_\_\_\_\_\_ Mood Swings | \_\_\_\_\_\_ Legs twitching/Jerking |
| \_\_\_\_\_\_ Excessive Sleepiness | \_\_\_\_\_\_ AFIB | \_\_\_\_\_\_ Forgetfulness |
| \_\_\_\_\_\_ Wake Up Choking | \_\_\_\_\_\_ Weight Gain | \_\_\_\_\_\_ Awakens Gasping for Air |
| \_\_\_\_\_\_ Confusion | \_\_\_\_\_\_ Depression | \_\_\_\_\_\_ Insomnia |
| \_\_\_\_\_\_ COPD | \_\_\_\_\_\_ Smoking | \_\_\_\_\_\_ TIA/History of Stroke |

**PATIENT RESPONSIBILITY:** I agree to return the sleep recorder, including the finger sensor, belt and tape to Toledo Clinic ENT in the same condition as it was dispensed to me for my sleep test. I also agree to return the sleep recording system by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or I will be financially responsible for its replacement.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date returned:\_\_\_\_\_\_\_\_\_\_\_\_ Patient signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Staff initials\*\_\_\_\_\_\_\_\_\_\_\_