AMERICAN HOME DIAGNOSTICS

HST DEVICE QUESTIONNAIRE

PATIENT DEMOGRAPHICS			SCORING
LAST	**FIRST**	**MIDDLE INITIAL**	Neck Size +2 ≥ 16.5 (Male) +2 ≥15.0 (Female)
DATE OF BIRTH	○ **MALE** ○ **FEMALE**	**ID#**	
HEIGHT ____ FEET _____ INCHES	**WEIGHT _____ POUNDS**	**NECK SIZE ____INCHES**	

MEDICAL CONDITIONS: **HAVE YOU BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS?**

+1 for each Yes response

HIGH BLOOD PRESSURE	○ Yes ○ No	STROKE	○ Yes ○ No
HEART DISEASE	○ Yes ○ No	DEPRESSION	○ Yes ○ No
DIABETES	○ Yes ○ No	SLEEP APNEA	○ Yes ○ No
LUNG DISEASE	○ Yes ○ No	NASAL OXYGEN USE	○ Yes ○ No
INSOMNIA	○ Yes ○ No	RESTLESS LEG SYNDROME	○ Yes ○ No
NARCOLEPSY	○ Yes ○ No	MORNING HEADACHES	○ Yes ○ No
SLEEP MEDICATION	○ Yes ○ No	PAIN MEDICATIONS	○ Yes ○ No

Do not assign any points for these eight responses

EPWORTH SLEEPINESS SCALE: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. 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 mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

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

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, Inactive, In a public place (theater, meeting, etc)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Epworth Score **TOTAL** the values from all 8 questions.
If 11 or less **Score = 0**
If 12 or more **Score = 2**

HABITS	**Never**	**Rarely 0-1 times/wk**	**Sometimes 1-2 times/wk**	**Frequently 3-4 Times/wk**	**Always 5-7 times/wk**
On Average in the past month, how often have you snored or been told that you snore?	○ +0	○+1	○+2	○+3	○+4
Do you wake up choking or gasping?	○+0	○+1	○+2	○+3	○+4
Have you ever been told that you stop breathing in your sleep or wake up choking or gasping?	○+0	○+1	○+2	○+3	○+4
Do you have problems keeping your legs still at night or need to move them to feel comfortable?	○+0	○+0	○+0	○+0	○+0

Habits Score **TOTAL** the values for all answers from first **3** habits questions

Would you be interested in participating in research? ○ Yes ○ No

The undersigned certifies that he/she is the patient or is duly authorized to complete and has completed this questionnaire.

Patient Signature_____ Date_____

Patient Phone Number_____

Physician Signature_____ Date_____

Physician (Printed)_____

Total all 4 boxes above.

Scoring chart
≤ = No Risk
4 or 5 Low Risk
6 to 10 = High Risk
≥ = Very High Risk

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