



7600 Hospital Dr. Suite E  
Sacramento, CA. 95823  
916-681-8838 Fax: 916-681-0411

**Very Important!!!!** The attached form is called the Epworth Sleepiness Scale.

**This form can be a deciding factor in your treatment.**

**We ask you to be very honest in your answers.**

**Please solicit the help of a partner or spouse that is familiar with your habits to help you decide what the proper answer should be.**

**There are no right or wrong answers but it helps us to determine just how sleepy you get in certain situations.**

**Remember, we are asking you to judge how likely you are to doze off or fall asleep and indicate your chance of dozing off. Just because you don't fall asleep in certain situations does not mean you are not likely to do so!**

**Please do not take this test lightly. It is very important and could affect your treatment options should you be diagnosed with a sleep disorder.**

**Do not forget to check the background indicators you may have experienced. Depending on the indicators checked, they may affect your treatment should you be diagnosed with a sleep disorder.**

**Thank you.**



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Patient Name: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Age: \_\_\_\_\_

**Check any of the following conditions you may have experienced:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Restless Sleep              | <input type="checkbox"/> Overweight        | <input type="checkbox"/> Heart Disease       |
| <input type="checkbox"/> Daytime drowsiness          | <input type="checkbox"/> History of Stroke | <input type="checkbox"/> Memory Loss         |
| <input type="checkbox"/> Witnessed Apneas (gaspings) | <input type="checkbox"/> Leg Cramps        | <input type="checkbox"/> Allergies/Sinusitis |
| <input type="checkbox"/> Loud Snoring                | <input type="checkbox"/> Anxiety           | <input type="checkbox"/> COPD                |
| <input type="checkbox"/> Hypertension                | <input type="checkbox"/> Loss of Energy    | <input type="checkbox"/> Hyperthyroidism     |
| <input type="checkbox"/> Mood Disorders              | <input type="checkbox"/> Depression        | <input type="checkbox"/> Hypothyroidism      |

Other \_\_\_\_\_

**Please list any current medications and their uses:** \_\_\_\_\_

\_\_\_\_\_

See how you may answer the following on the Epworth Sleepiness Scale:  
 How likely are you to doze off or fall asleep in the following situations? Even if you have not experienced some of these situations recently, try to imagine how they would have affected you.

SITUATION	SCORE	CHANCE OF DOZING
Sitting and reading		0= Never 1= Slight 2= Moderate 3= High
Watching TV		
Sitting, inactive in a public place (e.g., theater, meeting)		
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		
Sitting quietly after a lunch without alcohol		
In a car, while stopped for a few minutes in traffic		
<b>TOTAL SCORE</b> _____		

**Please answer the following questions regarding any past CPAP or BiPAP use:**

- Have you ever used a CPAP or BiPAP device, other than during a sleep study? Yes \_\_\_\_\_ No \_\_\_\_\_
- Have you ever received a CPAP or BiPAP device from another medical supply company? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If so, when? (Approximate date, if exact not known) \_\_\_\_\_  
 Which company provided your equipment? \_\_\_\_\_
- Do you still have possession of that device? Yes \_\_\_\_\_ No \_\_\_\_\_  
 When and why was the device returned? Date: \_\_\_\_\_ Why? \_\_\_\_\_

**Please be aware that insurance providers MAY NOT ALLOW replacement of a CPAP or BiPAP device if you have been provided one in the past. If you have received a CPAP or BiPAP device from another medical supply provider and it is still functioning properly, your insurance provider may deny payment of the device we provide you, as "not reasonable and necessary". By signing the financial consent form, you assume all financial liability of any and all new device rental periods and/or purchase if your insurance provider denies payment of the equipment due to another device having already been provided by another medical supplier. Initials \_\_\_\_\_**