Patient Information

Patient Name: _____ DOB:_____/_____/_____

☐ Male ☐ Female   Height: _____ FT_____IN   Weight:_____lbs.

S.P.O.T. Apnea Quiz

			Yes	No
1.	**S**nore	Do you **snore** loudly?	☐	☐
2.	**P**ressure	Do you have or are you being treated for high blood **pressure**?	☐	☐
3.	**O**bserved	Has anyone **observed** you stop breathing during your sleep?	☐	☐
4.	**T**ired	Do you often feel **tired**, fatigued, or sleepy during the day?	☐	☐

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 choose the most appropriate number for each situation:

0 - **NO** chance of dozing   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 (e.g. theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking with someone	_____
In a car, while stopping for a few minutes in traffic	_____
Epworth Score (Total)	_____

Conclusion

Discuss these results with your physician to determine your risk for sleep apnea if:

☐ You answered **"Yes"** to **two** or more questions in the S.P.O.T. Quiz **or**

☐ You answered **"Yes"** to **one** and to any of the following criteria below:

　☐ Male ☐ Large Neck ☐ Overweight ☐ Over 50 **(Check all that apply)**

☐ Epworth Sleepiness Scale is a 9 or higher

Physician Comments

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