WATERMARK MEDICAL ARES QUESTIONNAIRE

Please take a moment to fill out this questionnaire to screen for Obstructive Sleep Apnea; highlighted areas to be filled in upon Dr. Burwell's review.

1. What is your neck size? If unknown, we will measure for you. _____

+2 Male ≥ 16.5
+2 Female ≥ 15.0 _____

2. Have you been diagnosed or treated for any of the following conditions? Please circle Y or N for each

Y / N	High blood pressure	Y / N	Stroke
Y / N	Heart disease	Y / N	Depression
Y / N	Diabetes	Y / N	Sleep Apnea

Co-morbidities: Assign +1 for each Yes Response _____

Y / N	Lung disease	Y / N	Nasal oxygen use
Y / N	Insomnia	Y / N	Restless leg syndrome
Y / N	Narcolepsy	Y / N	Morning fatique
Y / N	Sleeping medication	Y / N	Pain medication

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.
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 score is 11 or less, ***score = 0.***
If score is 12 or more, ***score = 2.*** _____

On average in the past month, how often have you snored or been told that you snored?
Never ☐ Rarely ☐ +1 Sometimes ☐ +2 Frequently ☐ +3 Almost always ☐ +4 _____

Do you wake up choking or gasping?
Never ☐ Rarely ☐ +1 Sometimes ☐ +2 Frequently ☐ +3 Almost always ☐ +4 _____

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ☐ Rarely ☐ +1 Sometimes ☐ +2 Frequently ☐ +3 Almost always ☐ +4 _____

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Almost always ☐

TOTAL ALL 6 SCORES _____

4 or 5 low risk; 6 to 10 high risk; 11+ very high risk