SLEEP STUDY CLINICAL QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____

SLEEP STUDY REQUESTED

CPT: 95805 MSLT ____ CPT: 95810 PSG _____ CPT:95811 PSG W CPAP TITRATION____

HEIGHT: _____ WEIGHT: _____ BMI: ____ NECK CIRCUMFERENCE: _____

EPWORTH SLEEPINESS SCORE (ESS): _____

COMPLAINTS:

HABITUAL SNORING: Y N

EXCESSIVE DAYTIME SLEEPINESS: Y N

WITNESSED APNEA EVENTS: Y N

CHOKING DURING SLEEP: Y N

GASPING WHILE SLEEPING: Y N

INSOMNIA: Y N

FREQUENT UNEXPLAINED AROUSALS FROM SLEEP: Y N

HYPERTENSION: Y N

MODERATE TO SEVERE CHF: Y N

COPD: Y N

OSA: Y N

PRIOR SLEEP STUDIES: _____

SPECIAL NEEDS CONTRINDICATING AN AT HOME SLEEP STUDY:

IMPAIRED COGNITION / DEMENTIA: Y N _____

OCCUPATIONAL OR SOCIAL LIMITATIONS: Y N _____

OTHER: Y N _____