

Are you one of the millions of people who suffer from a sleep disorder?

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

Scoring:

0 = no chance of dozing

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Situation	Frequency
Sitting & Reading	0 1 2 3
Watching Television	0 1 2 3
Sitting inactive in a public place	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 possible	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in traffic	0 1 2 3

TOTAL: _____

If you score nine or higher, please give this to your physician to discuss various treatment options.

Answer these questions:

1. Do you snore loudly? Yes No

2. Do you often feel tired, fatigued or sleepy during daytime? Yes No

3. Has anyone observed you stop breathing during sleep? Yes No

4. Do you have or are you being treated for high blood pressure? Yes No

If you answered 'yes' to two or more of these questions you may have obstructive sleep apnea (OSA). Contact your physician and ask about getting a sleep study.

Your information:

Name: _____ Date of birth: _____

Male Female Height: _____ Weight: _____ Neck Circumference: _____

(Men with a neck circumference of 17" or above and women with 16" or above may be at risk for sleep apnea.)

Have you ever had a formal overnight sleep study? Yes No

If yes, where: _____ Date of study: _____

Phone: _____ Fax: _____

Please send me text messages/reminders to my cell phone – Cell phone: _____

Please send me email messages about trend and market data for sleep patients, replacement supplies, product updates and newsletters.

Email address: _____

Street address: _____

City: _____ State: _____ Zip: _____

For information on sleep apnea or sleep testing clinics, visit: www.graymarkhealthcare.com



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