

# Sleep Assessment Questionnaire

PulmoCrit Associates • (844) 428-5864 • pulmocrit.com

Name:  
\_\_\_\_\_

Age:  
\_\_\_\_\_

Date:  
\_\_\_\_\_

Height:  
\_\_\_\_\_

Weight:  
\_\_\_\_\_

BMI:  
\_\_\_\_\_

Blood Pressure:  
\_\_\_\_\_

Neck (in):  
\_\_\_\_\_

## PATIENT MUST COMPLETE THIS PART

Question	Yes	No
Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>
Are you unable to stay awake in the daytime?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up with a headache in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up in the middle of the night unable to breathe or gasping for air?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have sudden episodes of loss of muscle control, especially during emotional situations?	<input type="checkbox"/>	<input type="checkbox"/>
Do your legs jerk at night or feel restless?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever feel unable to move when falling asleep or waking up?	<input type="checkbox"/>	<input type="checkbox"/>
Have you gained a lot of weight in a short time?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a hard time staying asleep?	<input type="checkbox"/>	<input type="checkbox"/>
Has someone seen you stop breathing while sleeping? If yes, for how long? _____	<input type="checkbox"/>	<input type="checkbox"/>

Do you frequently wake up with (circle all that apply): **Dry Mouth • Stuffy Nose • Headache • Heartburn • Chest Pain • Choking & Gasping**

**Epworth Sleepiness Scale** — How likely are you to doze off or fall asleep (not just feel tired) in the following situations? 0 = Never 1 = Slight 2 = Moderate 3 = High chance

Situation	0	1	2	3
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting, inactive, in a public place (theater, meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when possible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PHYSICIAN MUST COMPLETE THIS PART — Check ONE and sign/date**

■ If patient meets health plan criteria for sleep study, proceed with home diagnostic sleep study (CPT 95806) with the group's preferred vendor. If home study is positive (AHI/RDI > 15, or 5–15 with co-morbidities), proceed with auto-titrate CPAP (5–20 cmH<sub>2</sub>O). If the patient is high-risk, proceed with a split-night in-lab sleep study with CPAP titration (CPT 95811).

■ Proceed directly to a split-night in-lab sleep study with CPAP titration (CPT 95811) with the group's preferred vendor. (NOTE: This option cannot be approved if criteria are not met for an in-lab study.)

**Physician  
Signature:**

**Date:**

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