Name : **Age:** **Weight:** **Height:** **Gender :** **M** **F**

Cell Phone :

Email :

Patient Sleepiness Scale :

Notes:

Step 1 : Answer "Yes" or "No" for the following questions. If you answer "Yes" also circle the corresponding points in the column to the right.

Step 2 : Total the points that you circle in the right column and record score in the space below.

Answer "Yes" or "No"	Yes	No	
Have you ever been told you stop breathing while asleep ?	☐	☐	8
Have you ever fallen asleep or nodded off while driving ?	☐	☐	6
Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing ?	☐	☐	6
Do you feel excessively sleepy during the day ?	☐	☐	4
Do you snore or have you ever been told that you snore ?	☐	☐	4
Have you had weight gain and found it difficult to lose ?	☐	☐	2
Have taken medication for, or been diagnosed with high blood pressure ?	☐	☐	2
Do you kick or jerk your legs while sleeping ?	☐	☐	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up ?	☐	☐	3

Do you wake up with headaches during the night or in the morning ?	☐	☐	3
Do you have trouble falling asleep ?	☐	☐	4
Do you have trouble staying asleep once you fall asleep ?	☐	☐	4

score : ----------

Risk Level :	Low	Moderate	High	Severe
Score :	0-7	8-11	12–15	16+