

SLEEP APNEA RISK ANALYSIS

First Name		Middle Initial		Last Name		Tally ARES Risk Points
Weight	Pounds	Age	Years	Gender Male <input type="radio"/> Female <input type="radio"/>		
Height	Feet	Inches	Neck Size		Inches	Neck Size +2 Male ≥16.5 +2 Female ≥15.0
Date of Birth	Month	Day	Year	ID Number		Optional

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?						Co-morbidities +1 for each Yes response
High blood pressure	Yes <input type="radio"/>	No <input type="radio"/>	Stroke	Yes <input type="radio"/>	No <input type="radio"/>	Score <div style="border: 1px solid black; width: 40px; height: 30px;"></div>
Heart disease	Yes <input type="radio"/>	No <input type="radio"/>	Depression	Yes <input type="radio"/>	No <input type="radio"/>	
Diabetes	Yes <input type="radio"/>	No <input type="radio"/>	Sleep apnea	Yes <input type="radio"/>	No <input type="radio"/>	
Lung disease	Yes <input type="radio"/>	No <input type="radio"/>	Nasal oxygen use	Yes <input type="radio"/>	No <input type="radio"/>	Do not assign any points for these eight responses
Insomnia	Yes <input type="radio"/>	No <input type="radio"/>	Restless leg syndrome	Yes <input type="radio"/>	No <input type="radio"/>	
Narcolepsy	Yes <input type="radio"/>	No <input type="radio"/>	Morning Headaches	Yes <input type="radio"/>	No <input type="radio"/>	
Sleeping Medication	Yes <input type="radio"/>	No <input type="radio"/>	Pain Medication e.g., vicodin, oxycontin	Yes <input type="radio"/>	No <input type="radio"/>	

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 for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze	1 = slight chance of dozing	0	1	2	3
2 = moderate chance of dozing	3 = high chance of dozing				

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

Frequency	0 - 1 times/week	1 - 2 times/week	3 - 4 times/week	5 - 7 times/week
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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

Signature	Area Code	Phone Number	Total all 6 boxes from above If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	Point Total <div style="border: 1px solid black; width: 40px; height: 30px;"></div>
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Fax to (718)229-3864 for our doctors to review and contact you. Please include your contact number above.