Beth Israel Deaconess Medical Center

A teaching hospital of Harvard Medical School

Welcome to your first Bariatric Evaluation appointment! The following is a quick questionnaire designed to help the medical staff assess your need for a sleep study as part of your surgical work-up. If you already have a diagnosis of Sleep Apnea please disregard this. Based on this questionnaire we will let you know if you need a sleep study and give you more information about sleep apnea and the necessary testing.

Sleep History:

1)Please answer the following:

	YES	NO
Do you have a history of snoring that is disruptive to others?	☐	☐
Has anyone ever told you that you stop breathing during sleep?	☐	☐
Do you ever awaken choking or gasping for air at night?	☐	☐

2) How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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.

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Sitting and reading	____
Watching TV	____
Sitting inactive in a public place	____
Being a passenger in a motor vehicle for an hour or more	____
Lying down in the afternoon	____
Sitting and talking to someone	____
Sitting quietly after lunch (no alcohol)	____
Stopped for a few minutes in traffic while driving	____
Total score	____

Total Score	
0-6	**Minimal Sleepiness**
7-8	**Average**
>/=9	**Excessive Sleepiness**