Martha A. Frankowski, M.D.
Diplomate, American Board of Psychiatry & Neurology
Diplomate, Subspecialty of Sleep Medicine

43650 Garfield ● Clinton Township, MI 48038 ● Phone (586) 263-0820 ● Fax (586) 263-3819 ● www.sleepandlivewell.com

SLEEP EVALUATION

Patient Name ______________________ Phone ______________ ID # ______________

Referring Physician ______________________ Phone ______________ Date _____/_____/_____

*By signing below, I authorize Sleep & Live Well Diagnostic Center staff and Martha A. Frankowski, M.D. to contact me regarding the disclosed health information.

Patient Signature ____

THE 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 choose the most appropriate number for each situation:

THE EPWORTH SLEEPINESS SCALE	CHANCE OF DOZING
No chance of dozing	0
Slight chance of dozing	1
Moderate chance of dozing	2
High chance of dozing	3

SITUATION:	CHANCE:
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL SCORE ⇨	

ANSWER THE FOLLOWING QUESTIONS:	YES	NO
Do you snore?		
Do you wake up gasping for air?		

Notes: ____

____

BMI: ____

MAL: ____

NC: ____

BERLIN SLEEP SCREENING

1. Height _______ Weight _______ Neck Circumference ________
2. Do you snore?
   - ☐ Yes
   - ☐ No
   - ☐ Don't Know

   If you snore:
3. Your snoring is?
   - ☐ Slightly louder than breathing
   - ☐ As loud as talking
   - ☐ Louder than talking
   - ☐ Very loud – Can be heard in adjacent rooms
4. How often do you snore?
   - ☐ Nearly every day
   - ☐ 3 – 4 times a week
   - ☐ 1 – 2 times a week
   - ☐ 1 – 2 times a month
   - ☐ Never or nearly never
5. Has your snoring ever bothered other people?
   - ☐ Yes
   - ☐ No
6. Has anyone noticed that you quit breathing during your sleep?
   - ☐ Nearly every day
   - ☐ 3 – 4 times a week
   - ☐ 1 – 2 times a week
   - ☐ 1 – 2 times a month
   - ☐ Never or nearly never
7. How often do you feel tired or fatigued after your sleep?
   - ☐ Nearly every day
   - ☐ 3 – 4 times a week
   - ☐ 1 – 2 times a week
   - ☐ 1 – 2 times a month
   - ☐ Never or nearly never
8. During your wake time, do you feel tired, fatigued or not up to par?
   - ☐ Nearly every day
   - ☐ 3 – 4 times a week
   - ☐ 1 – 2 times a week
   - ☐ 1 – 2 times a month
   - ☐ Never or nearly never
9. Have you ever nodded off or fallen asleep while driving a vehicle?
   - ☐ Yes
   - ☐ No

   If yes, how often does it occur?
   - ☐ Nearly every day
   - ☐ 3 – 4 times a week
   - ☐ 1 – 2 times a week
   - ☐ 1 – 2 times a month
   - ☐ Never or nearly never
10. Do you have high blood pressure?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know