

PRINT IN CAPITAL LETTERS - STAY WITHIN THE BOX All Fields Required-unless otherwise specified

Last Name			First Name		Middle Initial	Gender	
						Male <input type="checkbox"/>	Female <input type="checkbox"/>
Date of Birth		Month	Day	Year	Weight	Pounds	Height
							Feet
							Inches
							Inches
Neck Size							
I.D. Number (optional)							

Tally ARES Risk Points

Neck Size
+2 Male ≥16.5
+2 Female ≥15

Score

Co-morbidities
+1 for each Yes response

Score

Do not assign any points for these eight responses

COMPLETELY FILL IN ONE SQUARE FOR EACH QUESTION - ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sleep Apnea	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Lung disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Nasal oxygen use	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Insomnia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Restless legs syndrome	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Narcolepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Morning Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sleep Medication	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pain Medication e.g. vicodin, oxycontin	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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
2 = moderate chance of dozing 3 = high chance of dozing

	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, etc)	<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 circumstances permit	<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"/>

Epworth Score
Total the values from all 8 questions.
If 11 or less
Score = 0
If 12 or more
Score = 2

Score

Frequency (Check one for each question): Never +0, Rarely +1 times/wk, Sometimes +2 times/wk, Frequently +3 times/wk, Almost Always +4 times/wk.

On average in the past month, how often have you snored or been told that you snored?

Never +0 Rarely +1 Sometimes +2 Frequently +3 Almost always +4

Do you wake up choking or gasping?

Never +0 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 +0 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

Assign points for each of the first three responses

I have personally completed this questionnaire.
Signature

Date

Phone Number

Epworth Sleepiness Scale:
If points total = 3 or lower (no risk)
4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)

Point Total