

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"/>
Month		Day	Year		Pounds	Feet	Inches	Neck Size		
I.D. Number (optional)										

<b>Tally ARES Risk Points</b>
Neck Size +2 Male ≥16.5 +2 Female ≥15
Score <input style="width: 40px; height: 20px;" type="text"/>

**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"/>

Co-morbidities +1 for each Yes response
Score <input style="width: 40px; height: 20px;" type="text"/>
Do not assign any points for these eight responses

**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

	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
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 <input style="width: 40px; height: 20px;" type="text"/>

**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
<input style="width: 40px; height: 20px;" type="text"/>
Point Total

I have personally completed this questionnaire. Signature	Date	Phone Number	<b>Epworth Sleepiness Scale:</b> If points total =3 or lower (no risk) 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)
<input style="width: 80px; height: 20px;" type="text"/>			<input style="width: 80px; height: 20px;" type="text"/>