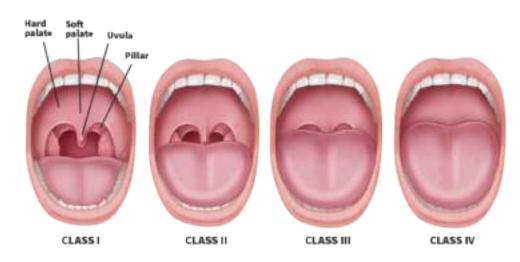
Sleep Health Questionnaire

				□ M □ F / /		
Patient Name				Gender DOB		
Address, City, State				Zip		
Cell Phone Alt. Phone			Email			
Medical Insurance Company	ID#			Group#		
Primary Care Physician's Name				Physician's Phone		
Patient Sleepiness Scale (Risk Factors): Please check all that apply.			pt.	Additional comments below:		
1. I have been told I stop breathing while	asleep		8			
2. I have fallen asleep or nodded off whi	le driving		6			
3. I've woken up with shortness of breat	n / gasping or my heart racing	;	6			
4. I feel excessively sleepy or fatigued du	iring the day		4			
5. I snore or have been told that I snore			4			
6. I have had weight gain and found it difficult to lose			4			
7. I have been diagnosed with high blood pressure			4			
8. It takes me less than 10 minutes to fall asleep			4			
9. I wake up more than 1 time per night			4			
10. I wake up with headaches			4			
Total points from above Check yo	ur Risk Level Score: 🔲 Low: 0	-7	Mode	erate: 8-11 🔲 High: 12-15 🗌 Severe: 16+		
Patient Health History (Signs & Symptoms):	Please check all that apply.			*Ask your doctor to complete below		
 Loud Snoring Depression/Anxiety Unrefreshed Sleep Upon Waking Memory Loss Irritability/Moodiness Wake Up with Dry Mouth Sinus/Allergy Issues Have CPAP Machine/Previous Dx of OSA 	 Diabetes History of Stroke/Heart Disease Acid Reflux/GERD Hypertension Witnessed Choking/Gasping/Apnea Family History of Sleep Apnea Deviated Septum Grind Teeth/Bruxism 			 BMI > 30 (see reverse) Narrow upper arch Visual airway obstruction Large/scalloped tongue Neck size: Male ≥ 16.5" or Female ≥ 16" <i>u</i> <i></i>		
Patient Signature	Date			inches B	PM	
I authorize this practice and EZ Sleep to have and release my medical information for the purpose of the coordination of care.			f care.	Neck Size Blood Pressure Heart Rate		
Prescription / Statement of Medica	l Necessity:			ain Insurance payers require a Risk Level Score of High /or least two (2) Signs & Symptoms sometimes up to four (4).		
Home sleep study (G47.33 to be used to rule out OSA, unless st Baseline (up to three-night home sleep test will be adm Follow Up / Assessment of oral applia 	ninistered based upon ordering provider or payer)		The Sleep Apnea Center of No Dr. James Ross D 23975 Novi Rd, Suite A-1 Novi, MI 483 NPI#: 122546528 State Lic#: 1357 Office Contact: Za	OS 04 75 9 73	
Dr. Signature I certify that above home sleep test is medically indicated and is reaso with reference to the standards of medical practice and treatment of t		ode: AS		Phone: 248-513-43		

Fax: 248-347-3647info@sleepbetter.expert• Phone: 248-513-4367Please fax or email completed form with copies of ID & medical insurance cards

Mallampati Score & BMI Chart

Visual Obstruction and Body Mass Index Reference Sheet



Normal Overweigh Obese Extreme Obesity BMI (kg/m2) Height Weight (inches) (pounds) 24.4



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