Tech Valley Sleep Center
at Community Care Physicians

Obstructive Sleep Apnea Screening Assessment

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Niskayuna, NY 12309

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Patient _____ Physician _____

ID# _____ Phone _____

Phone(H) _____(W)_____ Copies to _____

Date _____ Phone _____

Pertinent Medical History: _____

_____

_____

_____

_____

Waking Assessment (Epworth Sleepiness Scale)

How likely are you to fall asleep or doze in the circumstances listed below?
When rating these situations, give highest consideration to recent events.
If you have never experienced one of the situations, estimate how you might have reacted.

0	1	2	3
No Chance	Slight Chance	Moderate Chance	High Chance

Chance of dozing	***Situation***
_____	• Sitting and reading
_____	• Watching TV
_____	• Sitting inactive in a public place (theater or meeting)
_____	• As a passenger in a car for an hour without a break
_____	• Lying down to rest in the afternoon
_____	• Sitting and talking to someone
_____	• Sitting quietly after lunch, without alcohol
_____	• In a car stopped for a few minutes in traffic
☐	

Total