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Sleep Disorder Interview

How did you become aware of this disorder?
What have you done about it?
What do you know about it and where did this information come from?
What are your personal issues with sleep disorder?
Do you have trouble going to sleep, staying asleep, or waking up?
Do you take a sleeping pill? Does it work?
Do you wake up refreshed or do you want more sleep?
Do you know the correlation between weight and sleep?
Do you know the correlation between diabetes type 2 and sleep?
Do you know the correlation between high blood pressure and sleep?
Do you know what your blood pressure is?
Do you know the correlation between cardiovascular disease and sleep?
How many hours do you sleep each night?
Do you have a daytime sleepiness problem?
Do you take power naps in the afternoon?
Rate your quality of sleep 1-10: 1=great, 10= horrible
Have you ever woken up gasping or choking?
Do you have morning headaches?
Do you maintain alertness while driving?
Have you had an auto accident that was your fault?
Have you had some near collisions?
Are there times of the day when it is hard for you to focus?
Do you have a family history of snoring or apnea?
Do you dream? Do you remember them?
Do you have headaches? How often? Pain level 1 – 10
Where is the headache located?
Do you clench or grind you teeth during daytime?
Do you have jaw pain, neck pain, or back pain?
Any other joint pain?
Are you a gum chewer?
Does reading, TV, movies, or meetings put you sleep?
Do you breath through your nose (both nostrils) easily?
Do you frequently clear your throat?
Do you take any medications? Why?
Do you have any neurological problems?
Do you have occasional heartburn or acid reflux problems?
Do you have anxiety attacks or moods of depression?
Is your job or life stressfull?
Are you generally a happy person and optimistic about the future?
Is there anything I did not ask that needs to be covered?

Member of the AADSM

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name		Middle Initial	Last Name		Tally ARES Risk Points
Weight	Pounds	**Age**	Years	Gender: Male ○ Female ○	Neck Size: +2 Male ≥16.5, +2 Female≥16.0
Height	Feet / Inches		**Neck Size**	Inches	
Date of Birth	Month / Day / Year		**ID Number**	Optional	Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

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

High blood pressure	Yes ○	No ○	Stroke	Yes ○	No ○
Heart disease	Yes ○	No ○	Depression	Yes ○	No ○
Diabetes	Yes ○	No ○	Sleep apnea	Yes ○	No ○
Lung disease	Yes ○	No ○	Nasal oxygen use	Yes ○	No ○
Insomnia	Yes ○	No ○	Restless leg syndrome	Yes ○	No ○
Narcolepsy	Yes ○	No ○	Morning Headaches	Yes ○	No ○
Sleeping Medication	Yes ○	No ○	Pain Medication e.g., vicodin, oxycontin	Yes ○	No ○

Co-morbidities +1 for each Yes response

Score

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

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
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 lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○

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

Score

Assign points for each of the first three responses

Frequency	0 - 1 times/week	1 - 2 times/week	3 - 4 times/week	5 - 7 times/week

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

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

Do you wake up choking or gasping?

Never ○ 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 ○ 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 ○

Signature	Area Code / Phone Number	Total all 6 boxes from above	Point Total
		If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	