Welcome to your first Bariatric Evaluation appointment! The following is a quick questionnaire designed to help the medical staff assess your need for a sleep study as part of your surgical work-up. If you already have a diagnosis of Sleep Apnea please disregard this. Based on this questionnaire we will let you know if you need a sleep study and give you more information about sleep apnea and the necessary testing.

**Sleep History:**

1) Please answer the following:

Do you have a history of snoring that is disruptive to others?  

[ ] YES  [ ] NO

Has anyone ever told you that you stop breathing during sleep?  

[ ] YES  [ ] NO

Do you ever awaken choking or gasping for air at night?  

[ ] YES  [ ] NO

2) How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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.

- 0 = no chance of dozing
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Sitting and reading  
Watching TV  
Sitting inactive in a public place  
Being a passenger in a motor vehicle for an hour or more  
Lying down in the afternoon  
Sitting and talking to someone  
Sitting quietly after lunch (no alcohol)  
Stopped for a few minutes in traffic while driving  

Total score  

**Total Score**

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6</td>
<td>Minimal Sleepiness</td>
</tr>
<tr>
<td>7-8</td>
<td>Average</td>
</tr>
<tr>
<td>&gt;=9</td>
<td>Excessive Sleepiness</td>
</tr>
</tbody>
</table>