SLEEP EVALUATION FORM
Tri-City Cardiology

Patient Name: _____ Date: _____ Date of Birth: _____

Trouble sleeping can impact your heart and your blood pressure. In an effort to promote cardiovascular health, we are committed to identifying patients with sleep disorders.

Please take a moment to place an "X" in the appropriate column next to each statement below. If you have marked "yes" next to two or more of these statements, further evaluation of your sleep patterns may be warranted. Your physician will be happy to further discuss this with you during your appointment.

	Yes	No
1. I snore often or disturb others with my snoring.		
2. I have been told of pauses or stopping breathing during sleep.		
3. I have difficulty waking up or I am sleepy during the day.		
4. I am tired during the day, take naps or fall asleep during activities like reading, working on a computer, or watching TV.		
5. I have headaches when I wake (more than 2 times per week).		
6. I often wake more than 3 times a night.		
7. I often wake to use the bathroom more than twice a night.		
8. I am being treated for at least one of the following conditions: high blood pressure, heart failure, or atrial fibrillation.		
9. I am prescribed to take 3 or more medicines for blood pressure.		
10. I am being followed for diabetes or pre-diabetes.		