

ADULT SLEEP SCREENING TOOL

	Yes	No	Comments
1. Have you ever been seen or treated by a doctor for a sleep disorder?			
If Yes, Doctor's name?			
Results of sleep study?			
2. Do you, or have you been observed to awaken during the night?			
3. Do you, or have you been observed to choke, gasp or hold your breath during sleep?			
4. Are you often sleepy during daily activities?			

(If "Yes" to any of the above,
document on Perioperative/Procedure Flow Sheet under "Identified Needs".)

Additional Medications and Dosages: Prescription & Over the Counter			
Name?	Amount? (mg or tabs)	Taken How Often?	Taken For?

Additional Surgical History - Operation(s) and Year	