# Watermark Medical ARES Questionnaire

***PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX***

| First Name | | Middle Initial | Last Name | |
|---|---|---|---|---|
| | | | | |

| | | | | |
|---|---|---|---|---|
| **Weight** | Pounds | **Age** | Years | Gender: **Male** ○ **Female** ○ |
| **Height** | Feet | Inches | **Neck Size** | Inches |
| **Date of Birth** | Month / Day / Year | | **ID Number** | Optional |

Tally ARES Risk Points

Neck Size
+2 Male $\geq$16.5
+2 Female$\geq$15.0

Score

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

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

| Condition | | | Condition | | |
|---|---|---|---|---|---|
| High blood pressure | Yes ○ | No ○ | Stroke | Yes ○ | No ○ |
| Heart disease | Yes ○ | No ○ | Depression | Yes ○ | No ○ |
| Diabetes | Yes ○ | No ○ | Sleep apnea | Yes ○ | No ○ |

Co-morbidities
+1 for each Yes response

Score

| Condition | | | Condition | | |
|---|---|---|---|---|---|
| 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 ○ |

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**

| Situation | 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

| **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 ○ | |

Assign points for each of the first three responses

| 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)** | |

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# Bed Partner Questionnaire

To be completed by the Patient's bed partner, without influence of the Patient. Please complete and have the Patient bring with them to their sleep study appointment.

Patient's Name: ______________________________ Date: ______________________
Relationship to Patient: ________________________________________________

Please estimate how many hours of sleep your bed partner gets:

| Sleep Schedule: | Hours Each Night: | How Long does it take to fall asleep? | How long is your partner awake during the night? |
|---|---|---|---|
| Work Days: | | | |
| Days Off: | | | |

Mark any positions your bed partner sleeps in: ☐ Back ☐ Side ☐ Stomach

Does your bed partner snore? ☐ Never ☐ Occasionally ☐ Often ☐ Unknown
If they snore, please mark the positions they snore in: ☐ Back ☐ Side ☐ Stomach

How loud is his/her snoring? ☐ 1 (Light) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ( Loud)

Does your bed partner do any of the following in his/her sleep? (Please mark all that apply)
☐ Gagging ☐ Choking ☐ Snorting ☐ Gasping ☐ Teeth Grinding ☐ Kicking their feet

| | Never | Occasionally | Often | Unknown |
|---|---|---|---|---|
| Does you bed partner take naps during the day? | | | | |
| Does your partner stop breathing in his/her sleep? | | | | |
| Does your bed partner fall asleep when driving? | | | | |
| Does he/she fall asleep without warning? | | | | |
| Does your bed partner kick their legs while sleeping? | | | | |
| Does your bed partner mumble, talk, or yell during sleep? | | | | |

Does your bed partner awaken during the night? ☐ Never ☐ Occasionally ☐ Often ☐ Unknown
If they awaken, how long does it take them to get back to sleep? Hrs: _____ Mins: _____ ☐ Unknown
Do you know why he/she awakens? ☐ Yes ☐ No If yes, Why? ____________________
______________________________________________________________________

Is you bed partner restless during sleep? ☐ Never ☐ Occasionally ☐ Often ☐ Unknown
Describe what they do when restless: ____________________________________
______________________________________________________________________
______________________________________________________________________