GENERAL PRACTICE SLEEP SCALE

Name		Date:
Address (optional)	Practice Name:	
Phone (optional)	Practice Location:	
Gender/Sex:	Height:	Weight:

1. **Female score 0, Male score 2**
2. **What is your age?**

	☐ 34 years or younger	☐ 35 to 45 years	☐ More than 45 years
Score	0	1	3

3. **What is your Body Mass Index (BMI)?**

	☐ Less than 25	☐25 to 30	☐30 to 40	☐ More than 40
Score	0	1	2	5

4. **What is your Neck circumference or Collar size?**

Female	☐ 35.5cm or less	☐35.5 to 38 cm	☐ More than 38 cm
Male	☐ 39.5cm or less	☐39.5 to 46 cm	☐ More than 46 cm
Score	0	4	5

Answer yes or no to the following questions. Once you have answered all questions, tally the number of questions you marked 'yes' to and write your score below.

5. **Do you snore loudly? Does your partner complain of your snoring – does it disturb others?**

	☐Yes	☐No
Score	3	0

6. **Has anyone ever seen you stop breathing, choking or gasping for air in you sleep?**

	☐Yes	☐No
Score	1	0

7. **Do you awake tired of unrefreshed in the morning?**

	☐Yes	☐No
Score	1	0

8. **Do you fall asleep easily (e.g. during meetings, watching TV etc.)**

	☐Yes	☐No
Score	1	0

9. **Do you suffer from high blood pressure, diabetes, heart disease, or Depression?**

	☐Yes	☐No
Score	1	0

TOTAL: _____

If the score is more than 7, further discussion needs to be considered for investigations and management strategies if appropriate

Darwin Respiratory & sleep health

Electronic version available for use at: www.darwinsleephealth.com.au
Online app available for use at: https://darwinsleephealth.netlify.app/