

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

| | | | | | | | |
|---------------|---------------|----------------|------------|-----------|------------------|---------------------------|---|
| First Name | | Middle Initial | | Last Name | | Tally ARES Risk Points | |
| Weight | Pounds | | Age | Years | | | Gender Male <input type="radio"/> Female <input type="radio"/> |
| | Height | Feet | | Inches | | Neck Size Inches | |
| Date of Birth | | Month | Day | Year | ID Number | Optional | |
| | | | | | | | |

Neck Size
+2 Male ≥16.5
+2 Female ≥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? | | | | | |
|--|---------------------------|--------------------------|--|---------------------------|--------------------------|
| High blood pressure | Yes <input type="radio"/> | No <input type="radio"/> | Stroke | Yes <input type="radio"/> | No <input type="radio"/> |
| Heart disease | Yes <input type="radio"/> | No <input type="radio"/> | Depression | Yes <input type="radio"/> | No <input type="radio"/> |
| Diabetes | Yes <input type="radio"/> | No <input type="radio"/> | Sleep apnea | Yes <input type="radio"/> | No <input type="radio"/> |
| Lung disease | Yes <input type="radio"/> | No <input type="radio"/> | Nasal oxygen use | Yes <input type="radio"/> | No <input type="radio"/> |
| Insomnia | Yes <input type="radio"/> | No <input type="radio"/> | Restless leg syndrome | Yes <input type="radio"/> | No <input type="radio"/> |
| Narcolepsy | Yes <input type="radio"/> | No <input type="radio"/> | Morning Headaches | Yes <input type="radio"/> | No <input type="radio"/> |
| Sleeping Medication | Yes <input type="radio"/> | No <input type="radio"/> | Pain Medication e.g., vicodin, oxycontin | Yes <input type="radio"/> | No <input type="radio"/> |

Co-morbidities
+1 for each Yes
response

Score

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 | 0 | 1 | 2 | 3 |
| 2 = moderate chance of dozing | 3 = high chance of dozing | | | | |

| | | | | |
|---|---|---|---|---|
| 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

Assign points for
each of the first
three responses

| 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 <input type="radio"/> | Rarely <input type="radio"/> +1 | Sometimes <input type="radio"/> +2 | Frequently <input type="radio"/> +3 | Almost always <input type="radio"/> +4 |
| Do you wake up choking or gasping? | | | | |
| Never <input type="radio"/> | Rarely <input type="radio"/> +1 | Sometimes <input type="radio"/> +2 | Frequently <input type="radio"/> +3 | Almost always <input type="radio"/> +4 |
| Have you been told that you stop breathing in your sleep or wake up choking or gasping? | | | | |
| Never <input type="radio"/> | Rarely <input type="radio"/> +1 | Sometimes <input type="radio"/> +2 | Frequently <input type="radio"/> +3 | Almost always <input type="radio"/> +4 |
| Do you have problems keeping your legs still at night or need to move them to feel comfortable? | | | | |
| Never <input type="radio"/> | Rarely <input type="radio"/> | Sometimes <input type="radio"/> | Frequently <input type="radio"/> | Almost always <input type="radio"/> |

| | | | | |
|-----------|-----------|--------------|---|---|
| Signature | Area Code | Phone Number | Total all 6 boxes from above If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk) | Point Total |
| | | | | <input style="width: 40px; height: 30px;" type="text"/> |