# 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** ◯ **Female** ◯

Neck Size +2 Male ≥16.5 +2 Female≥15.0

| | | | |
|---|---|---|---|
| **Height** | Feet | Inches | **Neck Size** |
| | | | |

Inches:

Score

| | | | |
|---|---|---|---|
| **Date of Birth** | Month | Day | Year |
| | | | |

**ID Number** — Optional

***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 ◯ | No ◯ | Stroke | Yes ◯ | No ◯ |
| Heart disease | Yes ◯ | No ◯ | Depression | Yes ◯ | No ◯ |
| Diabetes | Yes ◯ | No ◯ | Sleep apnea | Yes ◯ | No ◯ |
| 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 ◯ |

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**
**2 = moderate chance of dozing** **3 = high chance of dozing**

| | 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

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 ◯ 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 to move them to feel comfortable?**

Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯ Almost always ◯

| 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)** | |