

Patient: _____
 Today's date: ___/___/___

DOB: ___/___/___
 BMI: _____

- Have you been told you have sleep apnea? Yes No
- Have you been told to wear a CPAP or any other device for breathing at night? Yes No
- If yes, do you wear it every night for the entire night? Yes No
- Do you take medication, supplements, or over-the-counter substances as sleep aids or headache relief? Yes No
- Do you feel rested in the morning? Yes No

Please check if you have any of the following:

- | | | |
|--|-------------------------------------|--|
| Heart Disease <input type="checkbox"/> | Insomnia <input type="checkbox"/> | Diabetes <input type="checkbox"/> |
| Headaches <input type="checkbox"/> | Depression <input type="checkbox"/> | Urination at night (nocturia) <input type="checkbox"/> |
| Acid Reflux <input type="checkbox"/> | Stroke <input type="checkbox"/> | Tooth grinding <input type="checkbox"/> |

STOP BANG SCORE:

- Do you SNORE? Yes No
- Do you feel TIRED? Yes No
- Has anyone OBSERVED you stop breathing during sleep? Yes No
- Do you have or are you being treated for high blood PRESSURE? Yes No
- Is your BMI > 30? Yes No
- AGE: Are you > 50 years old? Yes No
- Is your NECK circumference > 16"? Yes No
- GENDER: Are you male? Yes No

Total Yes Responses: _____

3-4 = Moderate Risk for OSA, 5-8 = High Risk for OSA

EPWORTH SLEEPINESS SCALE:

Please indicate your chance of dozing off in the following situations using the following:

- 0- Would never doze
- 1- Slight chance of dozing
- 2- Moderate chance of dozing
- 3- High chance of dozing

- | | |
|---|--|
| Sitting and Reading _____ | Laying down to rest in afternoon (when able) _____ |
| Watching TV _____ | Sitting and talking with someone _____ |
| Sitting, inactive in public _____ | Sitting quietly after lunch (w/o alcohol) _____ |
| As a passenger in a car for an hour _____ | In a car, stopped for a few minutes in traffic _____ |

Total: _____

0-6 Normal, 7-14 Mild Sleepiness, 15-17 Moderate Sleepiness, 18+ Severe Sleepiness

FOR OFFICE USE ONLY:

Patient meets the criteria for a comprehensive sleep evaluation and/or diagnostic sleep study. YES NO