

Sleep Screening Questionnaires

Please answer the questions below to help us assess for possible sleep apnea, a condition in which your breathing pauses or stops for periods of time while you sleep. Sleep apnea can increase your risk for many health conditions. It can also increase your risk for breathing problems after surgery.

Name _____ Date _____
DOB _____ Height _____ Weight _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| Have you ever been diagnosed with obstructive sleep apnea (OSA)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you currently being treated for OSA? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you aware of a family history of OSA? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you aware of clenching or grinding your teeth at night? | <input type="checkbox"/> | <input type="checkbox"/> |

ESS: Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze

2 = I have a moderate chance of dozing

1 = I have a slight chance of dozing

3 = I have a high chance of dozing

Situation

Chance of Dozing

- | | |
|---|-------|
| 1. Sitting and reading | _____ |
| 2. Watching TV | _____ |
| 3. Sitting inactive in a public place (e.g. a theatre or a meeting) | _____ |
| 4. As a passenger in a car for an hour without a break | _____ |
| 5. Lying down to rest in the afternoon when circumstances permit | _____ |
| 6. Sitting and talking to someone | _____ |
| 7. Sitting quietly in a lunch without alcohol | _____ |
| 8. In a car while stopped for a few minutes in traffic | _____ |

STOP - BANG

- | | | Yes | No |
|----------------|--|--------------------------|--------------------------|
| 1. Snore | Do you snore loudly? (Louder than talking or loud enough to be heard behind a closed door?) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Tired | Do you often feel tired, fatigued or sleepy during daytime? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Obstruction | Has anyone observed you stop breathing during your sleep? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Pressure | Do you have or are you being treated for high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. BMI | Is your body mass index greater than 28? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Age | Are you 50 years old or older? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Neck | Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Gender | Are you a male? | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Signature