SLEEP SCREENING

Patient Information

First Name: MI:

Last Name:

Height: Weight:

Gender: F or M Age:

BMI (Calculated): Neck Size:

STOP BANG Screener (Check Yes or No)

	YES	NO
S (snore) Do You Snore?	☐	☐
T (tired) Do you feel fatigued during the day? Do you wake up feeling like you haven't slept?	☐ ☐	☐ ☐
O (obstruction Have you been told you stop breathing at night? Do you gasp for air or choke while sleeping?	☐ ☐	☐ ☐
P (pressure) Do you have high blood pressure? Are you on medication to control high blood pressure?	☐ ☐	☐ ☐

Score: If you checked YES to 2 or more questions on the STOP portion you are at risk for OSA.

Check YES or NO

	YES	NO
B (BMI) Is your body mass index greater than 28?	☐	☐
A (age) Are you 50 years old or older?	☐	☐
N (neck) Are you a male with a neck circumference greater than 17 inches, or a female with circumference greater than 16 inches?	☐	☐
G (gender): Are you a Male?	☐	☐

Score: The more questions you checked YES on the BANG portion, the greater you're at risk of having moderate to severe OSA.

Epworth Sleepiness Scale- Rate 0-3

How likely are you to doze off or fall asleep in the situation described below, in contrast to feeling just tires? This refers to your usual way of life in recent times. Even if you haven't done some recently. Try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0= would never doze
1= slight chance of dozing
2= moderate chance of dozing
3= high chance of dozing

Please fill in the box with the scale number.

Sitting Reading	☐
Watching TV	☐
Sitting inactive in a public place (E.g. a theatre or a meeting)	☐
Sitting in a car as a passenger for a continuous hour	☐
Lying down to rest in the afternoon when circumstances permit	☐
Sitting and talking to someone	☐
Sitting quietly after a lunch without alcohol	☐
Sitting in a stopped car in traffic for a few minutes	☐
Total:	☐

The higher your scale, the greater the chance that you are at risk for OSA.

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ANDROS ENT
EAR NOSE THROAT & SLEEP CENTER

NAME _____ DATE OF BIRTH _____

1. Have you ever had a sleep study? YES NO
   If yes, when and where? _____
2. Have you ever been diagnosed with a sleep problem? YES NO
   If yes, which one? _____
3. Do you snore? YES NO (If no, go to question #7)
4. How long have you snored? _____
5. In which positions do you snore?
   BACK ONLY ALL POSITIONS (circle one)
6. Do you snore if you fall asleep in a chair? YES NO
7. Do you have a dry mouth in the morning? YES NO
8. Do you have headaches in the morning? YES NO
9. Do you dream while asleep at night? YES NO
10. Do you feel sleepy during the day YES NO (if no, go to question #12)
11. Is your daytime sleepiness worsening? YES NO
12. Do you take daytime naps? YES NO (if no, go to question #17)
13. How many naps do you take per week? _____
14. How long do your naps last? _____
15. Do you dream during naps? YES NO
16. Are the naps refreshing? YES NO
17. Have you ever had a close call or accident while driving because of sleepiness? YES NO
18. Do you suffer from memory problems? YES NO
19. Are you more irritable lately? YES NO
20. Have you ever had sudden loss of strength in arms or legs when laughing or scared? YES NO
21. Have you ever felt paralyzed when you first wake up, or when you fall asleep? YES NO
22. Do you sleep walk? YES NO
23. Do you sleep talk? YES NO
24. Do you ever have urinary accidents in bed? YES NO
25. Do you have nightmares? YES NO
26. What time do you go to bed? _____
27. What time do you wake up? _____
28. What are your working hours? _____ YES NO N/A (go to #30)
29. Is this a regular or rotating schedule? (circle one)
30. How long does it take to fall asleep? _____
31. Do you wake up in the middle of the night? YES NO (if yes go to #32)
32. How many times? _____
33. Do you fall asleep easily? YES NO
34. How many cups of caffeine do you have a day ____Coffee ____Tea ____Soda
35. Do you use over the counter or prescription sleep medications? YES NO (if yes, please list)