

Sleep Screening



Patient Information

| | | | | |
|------|--------|------------------|-----|-----------|
| Name | Height | Age | DOB | Gender |
| | Weight | BMI (calculated) | | Neck Size |

STOP BANG Screener (Check Yes or No)

YES NO

S (snore)

Do you snore loudly?

YES NO

T (tired)

Do you feel fatigued during the day?
Do you wake up feeling like you haven't slept?

YES NO

O (observed)

Have you been told you stop breathing at night?
Do you gasp for air or choke while sleeping?

YES NO

P (pressure)

Do you have high blood pressure or are on medication to control high blood pressure?

YES NO

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

B (BMI)

Is your body mass index greater than 35?

YES NO

A (age)

Are you 50 years old or older?

YES NO

N (neck) Are you a male with neck circumference greater than 17 inches, or a female with neck circumference greater than 16 inches?

YES NO

G (gender)

Are you a male?

YES NO

SCORE: The more questions you checked YES to on the BANG portion, the greater your risk of having moderate to severe OSA. A score of 3 or more suggests high risk of OSA.

Based on Chung F. et. al., Anesthesiology V 108, No 5, 812-21

Epworth Sleepiness Scale (Rate with 0 - 3 scale)

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things 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

| | 0 | 1 | 2 | 3 |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| Sitting and reading | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Watching TV | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting inactive in a public place (e.g. a theater or a meeting) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting in a car as a passenger for a continuous hour | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lying down to rest in the afternoon when circumstances permit | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting and talking to someone | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting quietly after a lunch without alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting in a car stopped in traffic for a few minutes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

TOTAL

SCORE: 0-9 Normal range 10 - 11 Borderline 12 - 24 Sleepy

Post Sleep Questionnaire



To be completed after patient's home sleep test

Name

Study date*

Time you fell asleep*

Typical duration of sleep*

Duration of sleep*

Current medications*

Main sleep complaint*

- Snoring
- Witnessed apnea (cessation of breath while sleeping)
- Excessive daytime sleepiness
- Other (explain in detail)

Medical history*

*Required information