**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)? | 🞏 | 🞏 |
| Are you currently being treated for OSA? | 🞏 | 🞏 |
| Are you aware of a family history of OSA? | 🞏 | 🞏 |
| Are you aware of clenching or grinding your teeth at night? | 🞏 | 🞏 |

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

|  |  |  |  |
| --- | --- | --- | --- |
| **STOP - BANG** |  |  |  |
|  |  | **Yes** | **No** |
| 1. **S**nore
 | Do you snore loudly? (Louder than talking or loud enough to be heard behind a closed door? | 🞏 | 🞏 |
| 1. **T**ired
 | Do you often feel tired, fatigued or sleepy during daytime? | 🞏 | 🞏 |
| 1. **O**bstruction
 | Has anyone observed you stop breathing during your sleep? | 🞏 | 🞏 |
| 1. **P**ressure
 | Do you have or are you being treated for high blood pressure? | 🞏 | 🞏 |
| 1. **B**MI
 | Is your body mass index greater than 28? | 🞏 | 🞏 |
| 1. **A**ge
 | Are you 50 years old or older? | 🞏 | 🞏 |
| 1. **N**eck
 | Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches? | 🞏 | 🞏 |
| 1. **G**ender
 | Are you a male? | 🞏 | 🞏 |

Patient Signature