Sleep Screening & Questionnaire

General Questions

First and Last Name: ______________________ Date of Birth: ______________________

Answer the following questions and provide requested information regarding your sleep.

Has anyone told you that you snore or are you aware that you snore?

☐ **Yes** ☐ **No**

Have you been diagnosed with sleep apnea?

☐ **Yes** ☐ **No**

Do you currently wear a oral appliance (for sleep apnea)?

☐ **Yes** ☐ **No**

Do you currently use a CPAP machine?

☐ **Yes** ☐ **No**

Do you take any sleeping medication

☐ **Yes** ☐ **No**

Rate your QUALITY of sleep:

☐ **Very Poor** ☐ **Poor** ☐ **Average** ☐ **Good** ☐ **Excellent**

Average hours of sleep per night:

☐ **Less than 4 hrs** ☐ **4 hrs** ☐ **5 hrs** ☐ **6 hrs** ☐ **7 hrs** ☐ **8 hrs** ☐ **More than 8 hrs**

Who do you sleep in the same room or bed with?

☐ **Spouse** ☐ **Partner** ☐ **Roommate** ☐ **Other family member** ☐ **I sleep alone**

Epworth Sleepiness Scale

For each scenario below, select the the most appropriate option based on your **likelihood of dozing off or falling asleep.** This refers to your usual way of life recently. If you have not done these recently, try and anticipate how they would have affected you today. The office will calculate your score which indicates your level of daytime sleepiness, if any.

Sitting and reading:

☐ **Never** ☐ **Slight Chance** ☐ **Moderate Chance** ☐ **High Chance**

Watching TV:

☐ **Never** ☐ **Slight Chance** ☐ **Moderate Chance** ☐ **High Chance**

Sitting inactive in a public place:

☐ **Never** ☐ **Slight Chance** ☐ **Moderate Chance** ☐ **High Chance**

Being a passanger in a motor vehicle for an hour or more:

☐ **Never** ☐ **Slight Chance** ☐ **Moderate Chance** ☐ **High Chance**

Lying down to rest in the afternoon:

☐ **Never** ☐ **Slight Chance** ☐ **Moderate Chance** ☐ **High Chance**

Sitting and talking to someone:

☐ **Never** ☐ **Slight Chance** ☐ **Moderate Chance** ☐ **High Chance**

Sitting quietly after lunch without alcohol:

☐ **Never** ☐ **Slight Chance** ☐ **Moderate Chance** ☐ **High Chance**

Stopping a few minutes in traffic while driving:

☐ **Never** ☐ **Slight Chance** ☐ **Moderate Chance** ☐ **High Chance**

Epworth Score:

____

What does my Epworth Score Mean?
0-10 Normal daytime sleepiness
11-15 Moderate daytime sleepiness. A sleep study is recommended for further evaluation.
16-24 Severe daytime sleepiness. A sleep study is highly recommended for further evaluation.

STOP-BANG Questionnaire

Complete each field/question below which may help determine if you are at risk for a potential sleep related breathing disorder. STOP-BANG stands for: **S**noring, **T**ired, **O**bserved you stop breathing, high blood **P**ressure; **B**MI, **A**ge, **N**eck size, **G**ender. The office will calculate your score based on your completion of all questions.

Age: ____________________

Gender: ☐ **Male** ☐ **Female**

Neck Circumference/Collar Size (inches): ______________________________

Height (feet): ____________________

(inches): ____________________

Weight (lbs): ______________________________

BMI (office to calculate):

____

Do you have snore loudly? (louder than talking or loud enough to be heard through closed doors)?

☐ **Yes** ☐ **No**

Do you often feel tired, fatigued, or sleepy during daytime?

☐ **Yes** ☐ **No**

Has anyone observed you stop breathing or pause in breathing during your sleep?

☐ **Yes** ☐ **No**

Has a physician told you that you have high blood pressure or do you take medication for high blood pressure?

☐ **Yes** ☐ **No**

STOP-BANG Score:

____

What does my STOP-BANG score mean?
0-2 Low risk for having obstructive sleep apnea
3-4 Moderate risk for having obstructive sleep apnea. A sleep study is recommended for further evaluation.
5-8 High risk for having obstructive sleep apnea. A sleep study is highly recommended for further evaluation.

NOSE Questionnaire

For each of the following five conditions below, select the most appropraite option regarding how much of a problem this has been for you over the past ONE MONTH. The office will calculate your score which indicates your level of nasal obstruction, if any.

Nasal congestion or stuffiness:

☐ Not a problem ☐ Very mild problem ☐ Moderate Problem ☐ Fairly bad problem ☐ Severe Problem

Nasal blockage or obstruction:

☐ Not a problem ☐ Very mild problem ☐ Moderate Problem ☐ Fairly bad problem ☐ Severe Problem

Trouble breathing through your nose:

☐ Not a problem ☐ Very mild problem ☐ Moderate Problem ☐ Fairly bad problem ☐ Severe Problem

Trouble sleeping:

☐ Not a problem ☐ Very mild problem ☐ Moderate Problem ☐ Fairly bad problem ☐ Severe Problem

Unable to get enough air through your nose during exercise or exertion:

☐ Not a problem ☐ Very mild problem ☐ Moderate Problem ☐ Fairly bad problem ☐ Severe Problem

NOSE Score:

____

What does the NOSE questionnaire score mean?
5-25 Mild nasal obstruction
30-50 Moderate nasal obstruction
55-75 Severe nasal obstruction
80-100 Extreme nasal obstruction