SLEEP APNEA SCREENING

☐M ☐F

Name | Gender | DOB

Address, City, State, Zip | Weight | Height

Cell Phone | Alt. Phone | Email

Medical Insurance Company | ID# | Group#

Section 1 - Patient Sleepiness Scale:

Step 1: Answer "Yes" or "No" for the following questions (circle Y or N). If you answer "yes" also circle the corresponding points in the column to the right.

Step 2: Total the points that you circled in the right column and record score in the space below.

Have you ever been told you stop breathing while asleep?	Y or N	8
Have you ever fallen asleep or nodded off while driving?	Y or N	6
Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	Y or N	6
Do you feel excessively sleepy during the day?	Y or N	4
Do you snore or have you ever been told that you snore?	Y or N	4
Have you had weight gain and found it difficult to lose?	Y or N	2
Have you taken medication for, or been diagnosed with high blood pressure?	Y or N	2
Do you kick or jerk your legs while sleeping?	Y or N	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Y or N	3
Do you wake up with headaches during the night or in the morning?	Y or N	3
Do you have trouble falling asleep?	Y or N	4
Do you have trouble staying asleep once you fall asleep?	Y or N	4
Score		

Risk Level	Low	Moderate	High	Severe
Score	0-7	8-11	12-15	16+

Section 2 - Signs & Symptoms (Check all that apply):

☐ Hypertension ☐ Snoring ☐ Diabetes

☐ Depression ☐ Grind Teeth ☐ Acid Reflux

☐ Stroke/Heart Disease ☐ Unrefreshed Sleep

☐ Family history of Snoring or Sleep Apnea

Section 3 - Sleep History (Check all that apply):

Have you ever been diagnosed with a sleep disorder? ☐Yes ☐No

Are you currently using a CPAP machine? ☐Yes ☐No

Do you use your CPAP less than 5 times a week? ☐Yes ☐No

Would you prefer an oral appliance? ☐Yes ☐No