Screening Sheet for

# Sleep Apnea

Name

Date

Email

Phone

## RISK ASSESSMENT

Obstructive Sleep Apnea (OSA) is a common, but serious medical condition that can affect your sleep, health and quality of life.

**OSA is dangerous.**

**It's important to treat OSA if you have it.**

If left untreated, OSA sufferers are at higher risk of:

- Heart attack
- Stroke
- Sleepiness that can lead to work related accidents and car crashes

Answer the following questions to find out if you are at risk. Your health is important to us!

| | | | |
|---|---|---|---|
| **S** | Snoring | Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? | ○ YES ○ NO |
| **T** | Tired | Do you often feel tired, fatigued, or sleepy during the day? | ○ YES ○ NO |
| **O** | Observed | Has anyone observed you stop breathing or gasp during sleep? | ○ YES ○ NO |
| **P** | Blood Pressure | Have you had, or are you currently being treated for, high blood pressure? | ○ YES ○ NO |
| **B** | BMI | Is your BMI (body mass index) greater than 35? | ○ YES ○ NO |
| **A** | Age | Are you over 50 years old? | ○ YES ○ NO |
| **N** | Neck Circumference | Is your neck size greater than 17" (male) 16" (female)? | ○ YES ○ NO |
| **G** | Gender | Are you male? | ○ YES ○ NO |

Screening for

# Obstructive Sleep Apnea

## MEDICAL HISTORY

Please check all that apply:

- ☐ Depression, irritability
- ☐ Morning headaches
- ☐ Memory and learning problems
- ☐ Trouble concentrating
- ☐ Mood swings, personality changes
- ☐ Chronic nasal congestion
- ☐ Family history of snoring or sleep apnea
- ☐ High blood pressure
- ☐ Stroke
- ☐ Heart disease
- ☐ Atrial fibrillation or other problems with your heart rhythm
- ☐ Type 2 diabetes
- ☐ Acid reflux
- ☐ Decreased sex drive

## SLEEP HISTORY

| | | |
|---|---|---|
| Have you ever had a sleep study or been told to get one? | ○ YES | NO ○ |
| Have you ever been diagnosed with a sleep disorder? | ○ YES | NO ○ |
| Do you wake up in the morning feeling unrefreshed? | ○ YES | NO ○ |
| Are you a restless sleeper? | ○ YES | NO ○ |
| Do you catch yourself nodding off during the day (at times when you shouldn't be)? | ○ YES | NO ○ |
| Does your bed partner sleep in another room because of your snoring? | ○ YES | NO ○ |
| Do you wake up frequently to urinate during the night? | ○ YES | NO ○ |
| Do you grind your teeth at night? | ○ YES | NO ○ |
| Have you ever had jaw clicking/pain, tooth sensitivity, or been told you have TMD? | ○ YES | NO ○ |
| Do you have a dry mouth or a sore throat when you wake up? | ○ YES | NO ○ |
| Have you **ever** used a CPAP machine? | ○ YES | NO ○ |
| Are you **currently** using a CPAP machine? | ○ YES | NO ○ |
| If yes, do you use your CPAP less than 5 times per week? | ○ YES | NO ○ |
| Have you tried CPAP and are looking for other treatment choices? | ○ YES | NO ○ |

Screening for

# Obstructive Sleep Apnea

## SLEEPINESS SCORE

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

| Situation | Chance of Dozing | | | | |
|---|---|---|---|---|---|
| Sitting and reading | 0 | 1 | 2 | 3 | |
| Watching TV | 0 | 1 | 2 | 3 | |
| Sitting, inactive in a public place (e.g. a theatre or a meeting) | 0 | 1 | 2 | 3 | |
| As a passenger in a car for an hour without a break | 0 | 1 | 2 | 3 | |
| Lying down to rest in the afternoon when circumstances permit | 0 | 1 | 2 | 3 | |
| Sitting and talking to someone | 0 | 1 | 2 | 3 | |
| Sitting quietly after a lunch without alcohol | 0 | 1 | 2 | 3 | |
| In a car, while stopped for a few minutes in traffic | 0 | 1 | 2 | 3 | |



Signature _____ Date _____