

Pre-Screening for Obstructive Sleep Apnea



Patient Name _____ Address _____ Date _____

City State Zip _____ Phone _____ DOB _____

Primary Care Physician _____ Phone _____

- *History of habitual snoring Yes No
- Has anyone told you that you Snore loudly (louder than talking) ? Yes No
- Do you often feel Tired, fatigued, or sleepy during daytime? Yes No
- *Do you have or are you being treated for high blood Pressure? Yes No
- *Has anyone observed you stop breathing during your sleep? Yes No
- Do you wake often during the night? Yes No
- Do you feel tired upon awakening? Yes No

SCORING: If you answered "YES" to two or more of these questions you may be at high risk for OSA.

Read the following situations and use the scale provided to rate your sleepiness.
 0 = would never doze
 1 = slight chance of dozing
 2 = moderate chance of dozing
 3 = high chance of dozing

Situation	never	slight	moderate	high
Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
As a passenger in a car for one hour without a break	0	1	2	3
Lying down to rest in the afternoon when time permits	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (without alcohol)	0	1	2	3
In a car, stopped for a few minutes in traffic	0	1	2	3

Total score _____

SCORING: Patients that score 10 or higher are affected by hypersomnolence (excessive daytime sleepiness) 0–9 range is considered to be normal, 11-15 indicates the possibility of mild to moderate sleep apnea, where a score of 16 and above indicates the possibility of severe sleep apnea .

For office use only:

Height _____ Weight _____ Neck _____ Diagnosed _____ CPAP _____ CPAP non compliant _____
 Pod# _____ Pulse ox _____