Pre-Screening for **O**bstructive **S**leep **A**pnea

KOPP DENTAL AND ASSOCIATES
RESTORATIVE, COSMETIC & IMPLANT DENTISTRY

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 .

Do you currently wear CPAP or BIOPAP ___Yes ___ No If yes are you currently wearing it regularly ___ Yes ___ No
Have you had a sleep study? ___Yes ___ No If yes please list location and date _____

I understand this is only a screening & not intended to diagnose a sleep disorder Signed_____

For office use only:

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