# SLEEP APNEA SCREENING

Sleep apnea is a common disorder characterized by repetitive collapse of the pharyngeal airway during sleep leading to oxygen deprivation.

**1. SNORING**

**a) Do you snore on most nights (more than 3x/wk)?** **YES (2)** **NO (0)**

**b) Can your snoring be heard through a door or walls?** **YES (2)** **NO (0)**

**2. STOP BREATHING**

**a) Has it ever been reported that you stop breathing or gasp during sleep?**

**NEVER (0)**
**OCCASIONALLY (3)**
**FREQUENTLY (5)**

**3. COLLAR SIZE**

**a) What is your collar size?**

**MALE** **<17 inches (0)**
**≥17 inches (5)**
**FEMALE** **<16 inches (0)**
**≥16 inches (5)**

**4. BLOOD PRESSURE**

**a) Have you had or are you being treated for high blood pressure?** **YES (2)** **NO (0)**

**5. DAYTIME SLEEPINESS**

**a) Do you occasionally doze or fall asleep during the day when:**

**You are not busy or active?** **YES(2) NO(0)**
**You are driving or stopped at a light?** **YES(2) NO(0)**

| | | |
|---|---|---|
| **9+ points** | **6-8 points** | **5 points or less** |
| **High probability** | **Probability** | **Low probability** |

***Consequences of untreated sleep apnea include:*** **sleep disruption, waking sleepiness, poor job performance, decreased quality of life, increased motor vehicle accidents, systematic hypertension, mild pulmonary hypertension, arrhythmias, myocardial infarction, stroke.**

NAME: _____

SIGNATURE: _____ DATE: _____

NAME: _____ DATE: ___/___/___

PRESENT WEIGHT: _____ HEIGHT: ____ BIRTHDATE: __/__/__ AGE: ___

WEIGHT GAINED IN PAST 12 MONTHS: _____

# EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale (ESS) was developed and validated by Dr. Murray Johns of Melbourne, Australia. It is a simple, self-administered questionnaire that is widely used by sleep professionals in quantifying the level of daytime sleepiness.

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling 'just tired'? This refers to your usual way of life at present and in the recent past. Even if you have not 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 | _____ |
| Watching television | _____ |
| Sitting, inactive in a public place (e.g. theatre, meeting) | _____ |
| As a passenger in a car for an hour without a break | _____ |
| Lying down to rest in the afternoon when circumstances permit | _____ |
| Sitting and talking to someone | _____ |
| Sitting quietly after lunch without alcohol | _____ |
| In a car, while stopped for a few minutes in traffic | _____ |
| **TOTAL SCORE** | _____ |

SIGNATURE: _____ DATE: _____

# SLEEP APNEA/SNORING QUESTIONNAIRE

1. How long have you been aware of your snoring?_____
2. Have you been told that you stop breathing while you are asleep? YES NO
3. Approximately how many times per night do you wake up? _____
4. Do you have any difficulty falling asleep at night? YES NO
5. How many hours of sleep per night do you get? _____
6. Do you most often wake up feeling refreshed? YES NO
7. Does a small amount of alcohol give you a headache? YES NO
8. Have you seen other doctors about snoring or apnea? YES NO
   WHO: _____
   WHEN: _____
9. Have you had a sleep lab study? YES NO When: _____
10. Do you have difficulty breathing through your nose? YES NO
11. Do you know if you have any heart irregularities? YES NO
12. Do you have high blood pressure? YES NO
13. Do you have any loss of memory? YES NO
14. Are you depressed? YES NO
15. What is your normal bedtime? _____
16. What is your normal wakeup time? _____
17. Does your work/sleep schedule change? YES NO
18. Does pain interfere with your sleep? YES NO
19. Have you ever fallen asleep behind the wheel? YES NO
    IF YES, how many times? _____

NAME: _____

SIGNATURE: _____ DATE: _____