Name_____ DOB _____ Neck Size_____ ___M__F Gender

Height_____Weight____Address_____

InsuranceCarrier_____ID_____ Phone Number_____

Do you smoke__Y__N Screening Date_____ Have You Been Tested Before ___ YES, WHEN_____ __NO

If Yes, Are you ready to quit smoking? __Y __N Referring Provider _____

Pt's Initial _____

STOP BANG Screener (Check Yes or No)	YES	NO
S (snore) Do you snore?	☐	☐
T (tired) Do you feel fatigued during the day? Do you wake up feeling like you haven't slept?	☐	☐
O (obstruction) Have you been told you stop breathing at night? Do you gasp for air or choke while sleeping?	☐	☐
P (pressure) Do you have high blood pressure or are on medication to control high blood pressure?	☐	☐
SCORE: If you checked YES to two or more questions on the STOP portion you are at risk for OSA.		
B (BMI) Is your body mass index greater than 25?	☐	☐
A (age) Are you 50 years old or older?	☐	☐
N (neck) Are you a male with neck circumference greater than 17 inches, or a female with neck circumference greater than 16 inches?	☐	☐
G (gender) Are you a male?	☐	☐
SCORE: The more questions you checked YES to on the BANG portion, the greater your risk of having moderate to severe OSA.		

Epworth Sleepiness Scale (Rate with 0 - 3 scale)

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

Pt's Initial _____

	0	1	2	3
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (e.g. a theater or a meeting)	☐	☐	☐	☐
Sitting in a car as a passenger for a continuous hour	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
Sitting in a car stopped in traffic for a few minutes	☐	☐	☐	☐
TOTAL				

Score: 0 - 7 Normal Range
8 -12 Positive Medium Risk
13 - 24 Positive High Risk

Patient's History	Yes	No
Patient Screening Education Patient Take Home Date of HST_____	☐	☐
Device Returned	☐	☐
Schedule for HST results	☐	☐

Negative **Mild/Moderate** **Severe**

Total Score: _____

Doctor's Notes:

_____

_____

_____

_____

_____

Post Sleep Questionnaire

To be completed after patient's home sleep test

Study date*

Time you fell asleep*

Typical duration of sleep*

Duration of sleep*

Current medications*

Main sleep complaint*

- ☐ Snoring
- ☐ Witnessed apnea (cessation of breath while sleeping)
- ☐ Excessive daytime sleepiness
- ☐ Other (explain in detail)

Medical history*

Patient has reviewed both sides of this form and the answers are true and correct to the best of this knowledge information and belief. The diagnosis and treatment of sleep apnea requires interaction of sleep professionals who share information in order to advice a treatment plan and I authorize the Sleep Specialist associated with my testing and treatment to share my medical information.

Print Name:

Signature: