Name_____Neck Size_____Age_____

Height_____Weight_____DOB_____Gender:FEMALE

Address_____Zip Code_____Tel._____

Insurance Carrier_____Card #_____

E-Mail Address_____AHI_____

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 28?	☐	☐
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

	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: 0–10 Normal range 10–12 Borderline 12–24 Sleepy

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

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

Check List: Visit One

Family members present **Yes** **No**

☐ **Doctor consults patient on OSA**

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*

SLEEP APNEA PATIENT CONSENT

The patient is responsible for returning the device in the same condition as it was received. The patient understands that they liable for any damage, loss or failure to return the above device on the assigned return date: ____/_____/_____. Failure to comply may result in the assessment of a late charge.

Sleep Apnea and the Sleep Apnea test have been explained to me. I hereby consent to take a home sleep test for sleep apnea provided by this medical center.

Print Name: **Date:**

Signature: