TM/Airway-Sleep Screening Form DATE:_____

Patient Name:_____ Male/Female Age:_____

Heart Disease	Headaches (Waking or Progressive?)	Tooth Grinding	Waking up to Pee
Hypertension	Depression	Insomnia	
Acid Reflux	Stroke	Diabetes	

Have you ever been told you have sleep apnea?	Y	N
Have you been told you require a CPAP or any other device for breathing at night?	Y	N
If Yes, do you wear it every night for the entire night?	Y	N
Do you take medication, supplements or over the counter meds as sleep aids or headache relief?	Y	N
Is it easy to get to sleep?	Y	N
Can you stay asleep?	Y	N
Do you feel rested in the morning?	Y	N
Do you experience sounds like popping or clicking in the jaw joints?	Y	N

STOP BANG SCORE:

S	Do You **SNORE**?	Y	N
T	Do you feel **TIRED**?	Y	N
O	Has anyone **OBSERVED** you stop breathing during sleep?	Y	N
P	Do you have or are you being treated for high blood **PRESSURE**?	Y	N

Weight: _____lbs Height:____'_____" Neck:_____"

_____Kg _____M

B	BMI > 30	Y	N
A	Are You 50 Y or old?	Y	N
N	Neck Circumfrence> 16"	Y	N
G	Gender	Y	N

Total Yes Responses: _____

*3-4 Moderate Risk for OSA, 5-8 High Risk for OSA

Epworth Sleepiness Scale: 0-Never doze 1-slight chance of dozing 2-moderate chance of dozing 3-High Chance

Sitting and reading	___	As a passenger in a car	___
Watching TV	___	Laying down to rest in afternoon(when able)	___
Sitting, inactive		Sitting quietly after lunch(without alcohol)	___
in a public place	___	In a car, stopped for a few minutes in traffic	___

TOTAL: _____

0-6 Normal, 7-14 Mild Sleepiness, 15-17 Moderate Sleepiness, 18+Severe Sleepiness

ROM: MO w/o pain ____ MO Pain____ LER____ LEL____ Protrusion ____

FOR OFFICE USE ONLY:

Patient meets the criteria for a comprehensive evaluation ◯ Yes ◯ NO