Patient Name:
DOB:
Telephone:

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Sleep Apnea Screeing Questionnaire

For Patients:

I. EPWORTH SLEEPINESS SCALE:

Rate the chance you would fall asleep or doze off during the following activities:
0 = never doze, 1= slight chance, 2=moderate chance, 3= high chance

Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in public (movie, meeting)	0	1	2	3
As a passenger in a car for an hour without break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch	0	1	2	3
In a car, while stopped in traffic	0	1	2	3
		Total:		

>10 (indicates pathological sleepiness)?: **Yes** **No**

II. GASP QUESTIONNAIRE:

Do you snore?	Yes	No	Not sure
Do you stop breathing while asleep?	Yes	No	Not sure
Do you have or are treated for high blood pressure or reflux?	Yes	No	Not sure
Are you tired or fatigued?	Yes	No	Not sure
Are you overweight?	Yes	No	Not sure

3 or more "Yes" or "Not sure" (80% chance OSA)?: **Yes** **No**

For Physicians:

III. OTHER RISK FACTORS FOR OSA:

1. Family History of snoring/sleep apnea	Yes	No
2. Neck size > 18 inches (men), 16 inches (women)	Yes	No
3. "Retrusive mandible" or "kissing tonsils"	Yes	No
4. Morning dry mouth or headache, decreased attention or libido.	Yes	No
5. Medical associations: A-Fib, CHF, MI/CVA, ADD, DM, Glaucoma	Yes	No

2 or more (associated risk factors)?: **Yes** **No**

I, II, III: Are 2/3 positive (>90% chance of treatable OSA)? **YES/NO**
"YES" indicates need for Overnight Split-Night Sleep Study

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Physician Signature/Date