Pulmonary & Critical Care Associates, P.C.

SLEEP APNEA QUESTIONNAIRE

PATIENT INFORMATION (Please print)	**Today's Date:**
Name:	**DOB:**

STOP-BANG

Have you had a motor vehicle crash or near miss associated with drowsiness or excessive daytime sleepiness? **(NEW PATIENTS ONLY)**	1 – YES 0 - NO
Do you snore LOUDLY?	1 – YES 0 - NO
Tired or sleepy during the daytime?	1 – YES 0 - NO
Has someone noticed that you stop breathing at night?	1 – YES 0 - NO
Do you have a history of high blood pressure?	1 – YES 0 - NO
Is your BMI greater than 35?	1 – YES 0 - NO
Are you over 50 years old?	1 – YES 0 - NO
Is your neck size greater than 16 inches (40 cm)	1 – YES 0 - NO
Gender	1 – Male 0 – Female
TOTAL SCORE	

EPWORTH SLEEPINESS SCALE

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

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