APNEA DENTAL SOLUTIONS OF TEXAS
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Sleep Habits/History

Name:_____ **D.O.B.:** _____

Patient Phone Number: _____

STOP-BANG OSA screen

1. Snoring:
Do you snore?
Yes No

2. Tired:
Do you often feel tired, fatigued, or sleepy during the daytime?
Yes No

3. Observed:
Has anyone observed you stop breathing druing your sleep?
Yes No

4. Blood Pressure:
Do you have or are you being treated for high blood pressure?
Yes No

5. Weight:
BMI more than 35 kg/m2
Yes No

6. Age:
Age over 50 Years old?
Yes No

7. Neck Circumference:
Neck circumference greater than 40 cm? (16 in)
Yes No

8. Gender:
Male
Yes No

High risk of OSA: answering yes to three or more items
Low risk of OSA: answering yes to less than three items

EPWORTH

Please indicate the chance of dozing in each situation using the scale below:

0 = no chance of dozing 1= slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
How many times do you get up at night?	_____

Total Score: _____

_____ _____

Signature of Patient or Parent of Minor **Date**

{I attest that this information is true, accurate and complete to the best of my knowledge}