CATALYST Medical Group | Valley Medical Center Division

SLEEP APNEA SCREENING

Patient Name: _____ DOB: _____

Have you ever been diagnosed with Sleep Apnea? ❑ Yes ❑ No

If so, what is your current treatment? ❑ CPAP ❑ BIPAP ❑ Oral Appliance ❑ Other: _____

STOPBANG Sleep Apnea Questionnaire:

1. Do you **S**nore loudly? (Meaning louder than talking or loud enough to be heard through doors?) ❑ Yes ❑ No
2. Do you often feel **T**ired, fatigued or sleepy during the daytime? ❑ Yes ❑ No
3. Has anyone **O**bserved you stop breathing, choke or gasp during your sleep? ❑ Yes ❑ No
4. Do you have or are you being treated for high blood **P**ressure? ❑ Yes ❑ No
5. Is your **B**ody Mass Index (BMI) more than 35? *(We will calculate this for you.)* *BMI* - _____ ❑ Yes ❑ No
6. **A**re you over 50 years old? ❑ Yes ❑ No
7. **N**eck circumference? *(We will measure this for you.)* ❑ Yes ❑ No
   a. Men – Shirt collar over 17 inches (43 cm) *Collar Size* - _____
   b. Women – Shirt collar over 16 inches (41 cm) *Collar Size* - _____
8. Male **G**ender? ❑ Yes ❑ No

How many questions above did you answer "Yes" to? _____

Patient Signature: _____ Date: _____

Thank you for completing this questionnaire. Your results will be discussed during your visit today.

Disclaimer: This screening tool is used only to assess your health risk associated with sleep apnea. Sleep apnea has many significant implications, some of which could be fatal if left untreated. As your provider, I am responsible for helping you promote health and well being. This screening tool is one way to do this. This simple and quick questionnaire has been proven to effectively screen for this type of treatable disease.

VALLEY MEDICAL CENTER, PLLC
Occupational Medicine Department
2315 Eighth Street · Lewiston, Idaho 83501
Tel: 208.746.1383 · Fax: 208.746.6348