

STOP BANG

Screening For Obstructive Sleep Apnea Syndrome

Answer the following questions to find out if you are at risk for Obstructive Sleep Apnea Syndrome.

STOP

S (SNORE)	Have you been told that you snore?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
T (TIRED)	Are you often tired during the day?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
O (OBSTRUCTION)	Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
P (PRESSURE)	Do you have high blood pressure or are you on medication to control high blood pressure?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

If you answered YES to 2 or more questions on the STOP portion you are at risk for Obstructive Sleep Apnea.

To find out if you're at moderate risk of Obstructive Sleep Apnea, complete the BANG questions below.

BANG

B (BANG)	Is your body mass index greater than 28?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
A (AGE)	Are you 50 years old or older?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
N (NECK)	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
G (GENDER)	Are you a male?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

The more questions you answer YES to on the BANG portion, the greater your risk of having moderate to severe Obstructive Sleep Apnea Syndrome.

Name _____ DOB ____/____/____ Date ____/____/____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

Use the following scale and circle the most appropriate number for each situation.

- 0 **Would Never**
- 1 **Slight Chance**
- 2 **Moderate Chance**
- 3 **High Chance**

SITUATION

CHANCE OF DOZING OFF OR FALLING ASLEEP

Sitting, Reading, or Doing Homework	0	1	2	3
Watching Television	0	1	2	3
Sitting, Inactive In A Public Place (Ex. Movie Theater)	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 Permitted	0	1	2	3
Sitting & Talking With Someone	0	1	2	3
Sitting Quietly After Lunch	0	1	2	3
In a Car Stopped for a Few Minutes in Traffic	0	1	2	3

Total Score (Range 0-24) _____

Total Scores of 10 or Higher Determine Excessive Daytime Sleepiness

Name _____ DOB ____/____/____ Date ____/____/____

Name _____ DOB ____/____/____

Height _____ Weight _____ BMI _____ DOT/FAA License YES NO

PLEASE CHECK ALL OF YOUR SYMPTOMS

Obstructive Sleep Apnea/PLMS

- ☐ Unusual Movements
- ☐ Tingling/Movement of Limbs
- ☐ Frequent Awakenings
- ☐ Witnessed Apneas
- ☐ Morning Headaches
- ☐ Loud Snoring
- ☐ Excessive Daytime Sleepiness
- ☐ Un-refreshed Sleep
- ☐ Choking/Gasping During Sleep

Parasomnia

- ☐ Teeth Grinding
- ☐ Bedwetting
- ☐ Nightmares/Unusual Dreams
- ☐ Unusual Movements
- ☐ Sleep Talking
- ☐ Sleep Walking

Narcolepsy

- ☐ Falls Asleep During Daytime Activities
- ☐ Excessive Daytime Sleepiness
- ☐ Non-Refreshing Daytime Naps
- ☐ Disrupted Sleep
- ☐ Difficult to Awaken
- ☐ Hallucinations
- ☐ Sleep Paralysis
- ☐ Sleep Drunkenness

PLEASE CHECK EVERYTHING THAT YOU HAVE BEEN OR ARE CURRENTLY BEING TREATED FOR

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke/Mini Stroke | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Cardiac Arrhythmia's | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Oxygen Dependent |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Physical Impairment | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Behavioral Disturbances | <input type="checkbox"/> Learning Disorder | <input type="checkbox"/> Cognitive Impairment | <input type="checkbox"/> Psychological Disorder |
| <input type="checkbox"/> Handicapped/Wheelchair | <input type="checkbox"/> Have A Caretaker | <input type="checkbox"/> Growth Retardation | <input type="checkbox"/> Failure To Thrive |
| <input type="checkbox"/> Weight Gain > 10% | <input type="checkbox"/> Weight Loss > 10% | <input type="checkbox"/> Chronic Opiate Narcotics Use | <input type="checkbox"/> Restless Legs Syndrome |
| <input type="checkbox"/> Craniofacial Abnormality | <input type="checkbox"/> Upper Airway Abnormality | <input type="checkbox"/> Hypertrophy of Tonsils/Adenoids | |

Have You Had Surgery In The Past 6 Months YES NO Type _____ Date ____/____/____

Have You Ever Had a Sleep Study YES NO Where _____ Date ____/____/____

Are You Currently Using PAP Therapy YES NO

Have Your Symptoms Returned YES NO

Are You Unable To Tolerate PAP YES NO

Are You Compliant With PAP YES NO

Is Your Employer Requiring a Sleep Test YES NO

EPWORTH SLEEPINESS SCALE

Please, tell us how likely you are to doze off in the following situations?

0-Would Never 1-Slight Chance 2-Moderate Chance 3-High Chance

Sitting & Reading or Doing Homework	0	1	2	3	Watching Television	0	1	2	3
Sitting Inactive In a Public Place	0	1	2	3	As a Passenger In a Car For An 1+ Hours	0	1	2	3
Lying Down To Rest In The Afternoon	0	1	2	3	Sitting & Talking To Someone	0	1	2	3
Sitting Quietly After Lunch	0	1	2	3	In a Car Stopped For a Few Minutes	0	1	2	3

Total Score _____

FOR PHYSICIAN ORDERING USE ONLY

☐ PSG Only ☐ PSG with PAP Titration ☐ PAP ReTitration ☐ PSG with MSLT ☐ Home Sleep Test

Physician Signature _____ Date ____/____/____

Orders Will Be Sent To:

Sleep Monroe Health 309 Stewart Road Monroe Michigan 48162 (P) 734-384-3922 (F) 734-384-3925