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?**	☐ **YES**	☐ **NO**
T (TIRED)	**Are you often tired during the day?**	☐ **YES**	☐ **NO**
O (OBSTRUCTION)	**Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?**	☐ **YES**	☐ **NO**
P (PRESSURE)	**Do you have high blood pressure or are you on medication to control high blood pressure?**	☐ **YES**	☐ **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?**	☐ **YES**	☐ **NO**
A (AGE)	**Are you 50 years old or older?**	☐ **YES**	☐ **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?**	☐ **YES**	☐ **NO**
G (GENDER)	**Are you a male?**	☐ **YES**	☐ **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 Drunkeness

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

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

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:

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