ESS: _____

STOP-BANG: _____

Patient Name: _____ Date: _____

Age: _____ Sex: _____ Weight: _____ Height: _____ Neck Circumference: _____

EPWORTH SLEEPINESS SCALE

Directions:

1. Please read the list of situations and answer how likely you would be to doze off or fall asleep, and not just tired, at these times.
2. The situations refer to the last three weeks.
3. Even if you have not done or been in these situations recently, please try to guess how they may have affected you.
4. Please use the following scale graded 0,1,2 and 3 for each situation and give the total.

0 = would never dose ***1 = slight chance of dozing***
2 = moderate chance of dozing ***3 = high chance of dozing***

Sitting and reading	_____
Watching Television	_____
Sitting quietly in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking with someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL	_____

THE STOP –Bang Questionnaire

(OSA screening tool)

1.	Do you **S**nore loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
2.	Do you often feel **T**ired, fatigued, or sleepy during the day?	Yes	No
3.	Has anyone **O**bserved you to stop breathing during your sleep?	Yes	No
4.	Do you have or are you being treated for high blood **P**ressure?	Yes	No
5.	**B**ody Mass Index (BMI) more than 35?	Yes	No
	(BMI = (your weight in pounds * 703) / (your height In inches * your height in inches))		
6.	**A**ge over 50 yr. old?	Yes	No
7.	**N**eck circumference greater than 40 cm?	Yes	No
8.	**G**ender male?	Yes	No

Scoring: Yes to 3 or more of the 8 questions indicate that you are High Risk for OSA. Answering less yes to less than three indicates that you are low risk for OSA