INTERSTATE SLEEP APNEA SOLUTIONS

Sleep Apnea Screening Form

PATIENT INFORMATION

Name: _____ DOB: _____ Sex: _____ Height: ____ft. ____in. Weight: _____lbs.

Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

HEALTH QUESTIONNAIRE

1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? ☐ Yes ☐ No
2. Do you often feel tired, fatigued, or sleepy during the daytime? ☐ Yes ☐ No
3. Has anyone observed that you stop breathing during your sleep? ☐ Yes ☐ No
4. Do you have or are you being treated for high blood pressure? ☐ Yes ☐ No
5. BMI more than 35kg/m2? ☐ Yes ☐ No
6. Age over 50 years old? ☐ Yes ☐ No
7. Neck circumference* greater than 40CM? ☐ Yes ☐ No * Neck measured by staff
8. Gender male? ☐ Yes ☐ No
9. Do you have or are being treated for diabetes? ☐ Yes ☐ No

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

Diagnosis: Code G0339

UNATTENDED SLEEP STUDY:

Home Sleep Test/Type 3 Portable for evaluation of Sleep Disorder Breathing-Diagnosis:

Comments:

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Examiner Signature: _____ Date: _____