Airway Aware

Obstructive Sleep Apnea - *Are You at Risk?*

Name ______________________ Date ______________________

MEDICAL HISTORY Please check all that apply:

Depression, Irritability		High Blood Pressure	
Morning Headaches		Stroke	
Memory and Learning Problems		Heart Disease	
Trouble Concentrating		Afib or other problems with your Heart Rhythm	
Mood Swings, Personality Changes		Type 2 Diabetes	
Chronic Nasal Congestion		Acid Reflux	
Family History of Snoring or Sleep Apnea		Decreased Sex Drive	

RISK ASSESSMENT Please check all that apply:

Is your sleep restless?	
Do you snore regularly?	
Do you grind your teeth while you sleep?	
Do You wake up from sleep gasping for air?	
Do you experience daytime fatigue regularly?	
Do you need to urintae frequently during sleep time?	
Do you wake up in the morning feeling unrefreshed?	
Do you have a dry mouth or a sore throat when you wake up?	
Have you ever had a sleep study or been told to get one?	
Have you ever been dignosed with Obstructive Sleep Apnea?	
Have you ever used a CPAP machine?	
Are you currently using a CPAP machine?	
If yes, do you use your CPAP less than 5 times per week?	
Have you tried CPAP and are looking for other treatment choices?	

Even a few check marks on this page is a RED FLAG.

Fill out the forms on the next page for more insight.

If you are concerned, you should take this completed form to your physician or call our office to arrange a consultation.

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ADJUSTED NECK CIRCUMFERANCE SCORE

Question	Yes	No	Score
Neck Size in Inches Multiplied by 2.5 =			
Do you have Diabetes or Hypertension?	Yes = 4	No = 0	
Do you Snore?	Yes = 3	No = 0	
Do you awaken while sleeping Choking or Gasping?	Yes = 3	No = 0	
Do you have Afib?	Yes = 4	No = 0	
Chart Total			

Probability of Obstructive Sleep Apnea < 43 Low 43 to 48 Intermediate >48 High

EPWORTH SLEEPINESS SCALE SCORE

Choose the most appropriate number for each situation:

0	Would never doze
1	Slight chance of dozing
2	Moderate chance of dozing
3	High chance of dozing

How likely are you to doze or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you havent done some of these things recently, try to work out how they would have affected you.

Situation	Chance of Dozing 0	1	2	3
Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theatre or a meeting)	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 circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total Score for Epworth Sleepiness Scale = ________

10 and over Suggests Excessive Daytime Sleepiness