Name:_____ Date:_____

Sleep Well WNC
Snore Less, Live Better

STOP BANG

Are you at risk for OBSTRUCTIVE SLEEP APNEA?

SNORING AND SLEEP APNEA QUESTIONAIRE:

Please circle if you have a history of:

Heart Disease	Fibromyalgia	Narcolepsy
Depression	Periodontal Disease	ADD/AHD
Difficulty Sleeping	Hypertension	Stroke
Diabetes	Morning Headaches	

Do you snore? _____
Do you wear a CPAP now? _____
Have you been diagnosed with Sleep Apnea? _____
If there was a non-surgical way to stop sleep snoring would you be Interested? _____

STOP

S (snore)	Have you been told 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 on medication to control high blood pressure?	YES	NO

If you answered YES to two or more questions on the STOP portion you are at risk for Obstructive Sleep Apnea. It is recommended that you contact your primary care provider to discuss a possible sleep disorder.

To find out if you are at moderate or severe risk of Obstructive Sleep Apnea, complete the BANG questions below.

BANG

B (BMI)	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.

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EPWORTH SLEEPINESS SCALE

Sitting and Reading	_____
Watching TV	_____
Sitting inactive in public place (theater)	_____
As a car passenger for an hour without a break	_____
Lying down in the afternoon to rest	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
in a car while stopped at a traffic light	_____

0 = No chance of dozing
1 = Slight Chance of dozing
2 = Moderate Chance of dozing
3 = High Chance of dozing

TOTAL = _____

THORNTON SNORING SCALE

My snoring affects my relationship with my partner	_____
My snoring causes my partner to be irritable or tired	_____
My snoring requires us to sleep in separate rooms	_____
My snoring is loud	_____
My snoring affects people when I am sleeping away from home	_____

0 = Never
1 = 1 night/week
2 = 2-3 nights/week
3 = 4+ nights/week

TOTAL = _____

Please list the main reason(s) you are seeking treatment for snoring or sleep apnea:

_____

Do you have other complaints?

- ☐ Frequent snoring
- ☐ Excessive Daytime Sleepiness (EDS)
- ☐ Difficulty falling asleep
- ☐ Waking up gasping / choking
- ☐ Morning headaches
- ☐ Neck or facial pain
- ☐ I have been told I stop breathing when I sleep
- ☐ Other: _____
- ☐ Difficulty maintaining sleep
- ☐ Choking while sleeping
- ☐ Feeling unrefreshed in the morning
- ☐ Memory problems
- ☐ Impotence
- ☐ Nasal problems, difficulty breathing through nose
- ☐ Irritability or mood swings

Subjective Signs and Symptoms

Rate your overall energy level (Low) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Rate your sleep quality (Low) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Have you been told you snore? YES / NO / SOMETIMES

Rate the sound of your snoring (Quiet) 1 2 3 4 5 6 7 8 9 10 (Loud)

On average, how many times per night do you wake up? _____

On average, how many hours of sleep do you get per night? _____

How often do you awaken with headaches? NEVER / RARELY / SOMETIMES / OFTEN / EVERYDAY

Do you have a bed partner? YES / NO / SOMETIMES **Do you sleep in the same room?** YES / NO

How many times per night does your bedtime partner notice you stop breathing?

SEVERAL TIMES PER NIGHT / ONCE PER NIGHT / SEVERAL TIMES PER WEEK / OCCASIONALLY / SELDOM / NEVER