Screening for Sleep Apnea

Name: _____

Ht: _____ Wt: _____ Age: _____ Male/Female: _____

	Questions	Please Circle Yes or No	
1.	A. Do you have sleep apnea?	Yes	No
	B. **If yes:** Do you have a working CPAP or BIPAP?	Yes	No
	****If you answered yes to both A & B, you are done with the survey, otherwise continue below.****		
2.	Do you SNORE?	Yes	No
3.	Do you often feel TIRED, fatigued, or sleepy during daytime?	Yes	No
4.	Has anyone OBSERVED you stop breathing during your sleep?	Yes	No
5.	Do you have or are you being treated for high blood PRESSURE?	Yes	No
6.	BMI is greater than 35?	Yes	No
7.	AGE over 50 years old?	Yes	No
8.	NECK circumference > 16 inches?	Yes	No
9.	GENDER: Male?	Yes	No

****Please count how many questions you answered yes.**
Use the key below to determine your risk of OSA (obstructive sleep apnea).

# of Yes's and Risk of OSA	Next Step
5 - 9 = HIGH RISK	Schedule with Crossroads Sleep Disorders Center **(618) 244-5500**
3 - 4 = INTERMEDIATE RISK	Talk with a doctor. Decide if you should meet with a pulmonologist.
0 - 2 = LOW RISK	No appointment necessary.

JOURNEY
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at Crossroads Community Hospital

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