Screening for Obstructive Sleep Apnea

Patient Name: _____ Date of Birth:_____

I have already been diagnosed with sleep apnea. **YES** **NO**

(if yes, you do not need to complete the rest of this form.)

1. **Snoring:** Do you snore loudly? **YES** **NO**
2. **Tired:** Do you often feel tired, fatigued, or sleepy during the day? **YES** **NO**
3. **Observed:** Has anyone observed you stop breathing during your sleep? **YES** **NO**
4. **Blood Pressure:** Do you have or are you being treated for high blood pressure? **YES** **NO**
5. **BMI:** BMI more than 35? **YES** **NO**
6. **Age:** Are you over 50 years old? **YES** **NO**
7. **Neck Circumference:** Neck circumference greater than 15 in (women) or 17 in (men)? **YES** **NO**
8. **Gender:** Male? **YES** **NO**

Risk **of** Obstructive Sleep Apnea:

High: Yes to 5-8 questions

Intermediate: Yes to 3-4 questions

Low: Yes to 0-2 questions

~904-260-1514 ~ 12078 San Jose Blvd Suite 1, Jacksonville, Florida 32223
~www.FirstCoastDentalSleepMedicine.com