[1] STOP-BANG & [2] EPWORTH Sleep Disorders Screening Tool

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Name_______________________________________ **DOB** _________________ **Date** _________________

[1] STOP-BANG Obstructive Sleep Apnea Questionnaire

Directions: Please circle **YES** or **NO** to the following questions to find your score:

Question		
Have you been told that you **SNORE**?	YES	NO
Are you often **TIRED** during the day?	YES	NO
Do you stop breathing or has anyone **OBSERVED** you stop breathing during sleep?	YES	NO
Do you have high blood pressure or take medication for high blood **PRESSURE**?	YES	NO
Is your **BMI** > 35? If you don't know, Enter your Height ________Weight ________	YES	NO
Is your **AGE** 50 years old or older?	YES	NO
Is your **NECK** circumference greater than 16 inches?	YES	NO
Is your **GENDER** male?	YES	NO

Low Risk	0-2 YES Answers	Moderate Risk	3-4 YES Answers	High Risk	5-8 YES Answers	Total YES Answers ⇨	

[2] EPWORTH Sleepiness Scale

Directions: Please rate how likely you are to doze or fall asleep in the following situations by circling the numbered response that best applies to you. If you have not done some of these activities recently, select what would most likely happen if you were in that situation.

0	Would **Never** Sleep	1	**Slight** chance of sleeping	2	**Moderate** chance of sleeping	3	**High** chance of sleeping

	Chance of dozing/sleeping			
Sitting and reading	0	1	2	3
Watching Television	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
In a car, while stopped for a few minutes in the traffic	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting inactive in a public place (example: a theater or a meeting)	0	1	2	3

Total > 10 is considered Excessive Daytime Sleepiness	Total > 16 is considered Severe Daytime Sleepiness	Total of Numbers added together ⇨	