Please fill out the following questionnaire to find out if you have the symptoms of obstructive sleep apnea. The answers to these questions will also indicate whether there may be a breathing disorder that is habitual and plays a role in sleep apnea, anxiety, mood swings, fibromyalgia and other maladies.

STOP BANG QUESTIONNAIRRE

Snoring: Do you snore and does it affect your partners sleep in such a way that they are woken or have to sleep in another room, or do you awaken from the sound or vibration of the palate?

_____ Yes _____ No

Tired: Do you feel tired, fatigued, have a feeling of no energy, or even possibly feel really energetic and then really tired and there is no in between, during the day? _____ Yes _____ No

Observed: Has anyone told you that when you sleep, you gasp for breath, stop breathing for a moment or longer, or have uneasy and unsteady or possibly difficulty breathing?

_____ Yes _____ No

Pressure: Have you been diagnosed or are on the borderline of having high blood pressure?

_____ Yes _____ No

Body Mass Index: Is your body mass greater than 35 kg/m^2? The calculation is converting weight in lbs to Kg (Your weight in pounds divided by 2.2) and dividing that by the conversion of your height in inches to meters and squaring it (multiply it by itself). Or do you consider yourself severely overweight. _____ Yes _____ No

Age: Are you 50 years or older? _____ Yes _____ No

Neck Size: If you are male, is your neck size 17 inches or greater? If you are female, is your neck size 16 inches or greater? _____ Yes _____ No

Gender: Are you male? _____ Yes _____ No

0-2 "Yes" Low risk

3 – 4 "Yes" Intermediate risk

5 – 8 "Yes" High Risk

Epworth Sleepiness Scale

How would you answer these question as part of a normal situation?

Rate the questions with the following numbers to decide the likelihood of this particular situation occurring.

0 = Never doze off

1 = Slight Chance of Falling asleep

2 = Moderate chance of it happening

3 = Most likely doze off

Situation **Chance of Falling Asleep (0 – 3)**

Watching TV at home ____

Sitting and Reading ____

Sitting inactive in a public place (theatre, waiting in the car) _____

As a passenger in a car for an hour or less _____

Lying done in the afternoon or needing a nap _____

Sitting and talking to someone _____

Falling asleep after lunch when it is calm _____

In a car driving at night or at a stop light _____

Cumulative Score

0 – 5 Low

6 – 10 Higher Than Normal

11 – 12 Mild Daytime Sleepiness

13-15 Moderate sleepiness

16 or higher Severe daytime sleepiness