STOP Questionnaire for Obstructive Sleep Apnea (OSA)

Name: ____

Family Physician: __________________________________

Height: _________ inches

Weight: _________ lbs

Age: _______

Male / Female

Body Mass Index (BMI): ____

Is your collar size S, M, L or XL? OR Neck Circumference: _________ cm / inches

The STOP Test Questions:
(Please circle one)

1. Snoring

Do you snore loudly (louder than talking or loud enough to be heard through closed door)? *Yes* *No*

2. Tired

Do you often feel tired, fatigued or sleepy during the day? *Yes* *No*

3. Observed

Has as 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*

Total ____ Yes ____ No

High risk of OSA: answering yes to two or more questions

Low risk of OSA: answering yes to less than two questions

Epworth Sleepiness Scale

Name: ______________________________________ Today's date: ______________

Your age (Yrs): ____________ Your sex (Male = M, Female = F): ______

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading	___
Watching TV	___
Sitting, inactive in a public place (e.g. a theatre or a meeting)	___
As a passenger in a car for an hour without a break	___
Lying down to rest in the afternoon when circumstances permit	___
Sitting and talking to someone	___
Sitting quietly after a lunch without alcohol	___
In a car, while stopped for a few minutes in the traffic	

THANK YOU FOR YOUR COOPERATION

© **M.W. Johns 1990-97**

Medical Necessity for Sleep Study

____
Print Name

Past Medical History (check all that apply)

- Sleep apnea
- Hypertension
- Congestive Heart Failure
- Coronary Artery Disease
- Stroke
- Atrial Fibrillation
- Nocturnal oxygen desaturation with unexplained right heart failure, polycythemia, or cardiac arrhythmias during sleep
- Obesity BMI>30Kg/m2
- Frequent nocturnal awakenings to urinate
- Hypnagogic/Hypnopompic hallucinations
- Sleep paralysis
- Violent or injurious behavior during sleep
- Periodic movements of limbs during sleep
- Awakens with headache
- Anxiety/Depression/Mood Disorder
- Diabetes
- Craniofacial or soft tissue abnormality
- Narcolepsy
- Restless Legs Syndrome
- Insomnia
- Other:____

Symptoms (check all that apply)

- Witness apneas during sleep
- Epworth >10 (Score:)
- STOP BANG >3
- Awakens with choking or gasping sensation
- persistent snoring
- Daytime sleepiness
- MVC or close call from falling asleep while driving
- Shift work
- Tired in morning after sleeping at night

Pertinent Physical Exam Findings

- Mallampati ____________________
- Tongue Appearance ____________________
- Airway ____________________
- Tonsils ____________________
- Wear ____________________

Other pertinent history:

____

____