TIGARD ORTHOPEDIC & FRACTURE CLINIC

SLEEP APNEA SCREENING

Name:_____ Gender:_____

Age: _____ Date of Birth:_____

Respiratory History:

[ ] Asthma/Bronchitis [ ] COPD/Emphysema [ ] Other:_____

Smoker History:

[ ] Current smoker, pack per day ____ [ ] Casual smoker, how often? _____ [ ] Former/Quit

Type(s):

[ ] Cigarettes [ ] Cigars [ ] eCig/Vapor [ ] Marijuana [ ] Other:_____

Tobacco History:

[ ] Current [ ] Former [ ] Chewing [ ] Snuff [ ] Dip

STOP: Assess risk of Obstructive Sleep Apnea. Complete the **STOP** questions below.

S (snore)	Have you been told you snore?	YES / NO
T (tired)	Are you often tired during the day?	YES / NO
O (obstruction)	Do you know if/ OR have you been told you stop breathing while sleeping?	YES / NO
P (pressure)	Do you have high blood pressure or on medication to control your high blood pressure?	YES / NO

BANG: Assess <u>moderate to severe risk</u> of Obstructive Sleep Apnea, complete the **BANG** questions below.

B (bang)	Height:_____ Weight:_____	
A (age)	Are you 50 years or older:	YES / NO
N (neck)	Are you a male with a neck larger than 17 inches, or a female with a neck greater than 16 inches?	YES / NO
G (gender)	[ ] Male [ ] Female	

Office Staff Only:

BMI _____

STOP _____

BANG _____

TOTAL _____