SLEEP ASSESSMENT

To help determine your risk of obstructive sleep apnea (OSA)

NAME: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

Have you been previously diagnosed with sleep apnea? ❑ Yes ❑ No

If so, are you currently using CPAP to treat OSA? ❑ Yes ❑ No

PLEASE ANSWER THE FOLLOWING EIGHT QUESTIONS 'YES' OR 'NO'

1. **Snoring:** Do you snore loudly ❑ Yes ❑ No
   (Loud enough to be heard through closed doors?)
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:** Answer **'Yes'** if your weight exceeds the amount listed for your height on the table to the below. ❑ Yes ❑ No

4'10"	4'11"	5'0"	5'1"	5'2"	5'3"	5'4"	5'5"	5'6"	5'7"	5'8"	5'9"	5'10"	5'11"	6'0"	6'1"	6'2"	6'3"	6'4"	6'5"
167	173	179	185	191	197	204	210	216	223	230	237	243	250	258	265	212	279	287	295

6. **Age:** Is your age over 50 years old? ❑ Yes ❑ No
7. **Neck circumference:** Is your neck circumference >40cm? ❑ Yes ❑ No
8. **Gender:** Are you Male? ❑ Yes ❑ No

INTERPRETATION

Add up all the **'YES'** answers using the formula to calculate your final score

High risk of OSA:	Yes to 5-8 questions
Intermediate risk of OSA:	Yes to 3 - 4 questions
Low risk of OSA:	Yes to 0 -2 questions

TOTAL SCORE: _____

SLEEP CENTER
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CHsleep.org

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Chestnut Hill Hospital
TOWER HEALTH
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