

Nighttime Sleepiness Evaluation

Screening Tool for Sleep Apnea

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Please answer the following questions.

1. Snoring

a) Do you snore on most night (> 3 nights per week)?

Yes (2)

No (0)

b) Is your snoring loud? Can it be heard through a door or wall?

Yes (2)

No (0)

2. Has it ever been reported to you that you stop breathing or gasp during sleep?

Never (0)

Occasionally (3)

Frequently (5)

3. What is your collar size?

Male: Less than 17 inches (0) more than 17 inches (5)

Female: Less than 16 inches (0) more than 16 inches (5)

4. Do you occasionally fall asleep during the day when:

a) You are busy or active?

Yes (2)

No (0)

b) You are driving or stopped at a light?

Yes (2)

No (0)

5. Have you had or are you being treated for high blood pressure?

Yes (1)

No (0)

TOTAL

Score

9 points or more

6-8 points

5 points or less

Refer to sleep specialist or order sleep study

Gray area, use clinical judgment

Low probability of sleep apnea

Name _____

Date _____