BARNES-JEWISH Hospital
BJC HealthCare

Washington University in St. Louis
SCHOOL OF MEDICINE

OBSTRUCTIVE SLEEP APNEA (OSA) RISK ASSESSMENT

Please check (✔) the appropriate box (☐), fill in the blank(s).
Then, total points (number in parenthesis) for each section.

ADDRESSOGRAPH

Initial: Do you have a prior diagnosis (by overnight sleep study) of obstructive sleep apnea?
- ☐ Yes, and I DO routinely use CPAP or similar device (Skip questionnaire)
- ☐ Yes, and I DO NOT routinely use CPAP or similar device (Skip questionnaire)
- ☐ No (Continue below)

SECTION 1: NIGHTTIME SYMPTOMS

1. Do you snore?
   - ☐ Yes (1)
   - ☐ No (0) (Skip to question 5.)
   - ☐ Don't know/refused (0)
2. If you snore, your snoring is:
   - ☐ Slightly louder than breathing (0)
   - ☐ As loud as talking (0)
   - ☐ Louder than talking (0)
   - ☐ Very loud; can be heard in adjacent rooms (1)
   - ☐ Don't know/refused (0)
3. How often do you snore?
   - ☐ Nearly every day (1)
   - ☐ 3 to 4 nights a week (1)
   - ☐ 1 to 2 nights a week (0)
   - ☐ 1 to 2 nights a month (0)
   - ☐ Never or nearly never/don't know (0)
4. Has your snoring ever bothered other people?
   - ☐ Yes (1)
   - ☐ No/don't know/refused (0)
5. Has anyone noticed that you quit breathing during your sleep?
   - ☐ Nearly every day (2)
   - ☐ 3 to 4 times a week (2)
   - ☐ 1 to 2 times a week (0)
   - ☐ 1 to 2 times a month (0)
   - ☐ Never or nearly never/don't know/refused (0)

TOTAL POINTS FOR **SECTION 1:**__________
If **greater than or equal to 2** this section is **Positive**

SECTION 2: DAYTIME SYMPTOMS

6. How often do you feel tired or fatigued after your sleep?
   - ☐ Nearly every day (1)
   - ☐ 3 to 4 times a week (1)
   - ☐ 1 to 2 times a week (0)
   - ☐ 1 to 2 times a month (0)
   - ☐ Never or nearly never/don't know/refused (0)
7. During your wake time, do you feel tired, fatigued, or not up to par?
   - ☐ Nearly every day (1)
   - ☐ 3 to 4 times a week (1)
   - ☐ 1 to 2 times a week (0)
   - ☐ 1 to 2 times a month (0)
   - ☐ Never or nearly never/don't know/refused (0)
8. Have you ever nodded off or fallen asleep while driving a vehicle?
   - ☐ Yes (1)
   - ☐ No/don't know/refused (0)
9. If yes, how often does it occur?
   - ☐ Nearly every day (1)
   - ☐ 3 to 4 times a week (1)
   - ☐ 1 to 2 times a week (0)
   - ☐ 1 to 2 times a month (0)
   - ☐ Never or nearly never/don't know/refused (0)

TOTAL POINTS FOR **SECTION 2:**__________
If **greater than or equal to 2** this section is **Positive**

SECTION 3: COMORBIDITIES

10. Do you have high blood pressure?
    - ☐ Yes (1)
    - ☐ No/don't know/refused (0)
11. BMI: __________kg/m^2
    - ☐ greater than $30kg/m^2$ (1)
    - ☐ less than or equal to $30kg/m^2$ (0)

TOTAL POINTS FOR **SECTION 3:**__________
If **greater than or equal to 1** this section is **Positive**

ADDITIONAL INFORMATION:

Do you choke or gasp most nights? ☐ Yes ☐ No
Handedness: ☐ Left ☐ Right Neck Circumference:________cm

SCORING: IF THREE SECTIONS ARE POSITIVE OR IF TWO SECTIONS ARE POSITIVE PLUS THE PATIENT'S NECK CIRCUMFERENCE IS GREATER THAN 40 CM, THEN THE PATIENT IS AT HIGH-RISK FOR OBSTRUCTIVE SLEEP APNEA
- ☐ **NOT HIGH-RISK FOR OSA**
- ☐ **HIGH-RISK FOR OSA**

Clinician: ______________________ ______________________ Date/Time:__________________
SIGNATURE REQUIRED PRINTED NAME REQUIRED

DO NOT WRITE BELOW THIS LINE

BJ 7-3343-2030

ORIGINAL - MEDICAL RECORDS
COPY - DEPARTMENT

BARNES-JEWISH Hospital
BJC HealthCare

Washington University in St. Louis
SCHOOL OF MEDICINE

OBSTRUCTIVE SLEEP APNEA (OSA) RISK ASSESSMENT

Please check (✔) the appropriate box (☐), fill in the blank(s).
Then, total points (number in parenthesis) for each section.

ADDRESSOGRAPH

Initial: Do you have a prior diagnosis (by overnight sleep study) of obstructive sleep apnea?
- ☐ Yes, and I DO routinely use CPAP or similar device (Skip questionnaire)
- ☐ Yes, and I DO NOT routinely use CPAP or similar device (Skip questionnaire)
- ☐ No (Continue below)

SECTION 1: NIGHTTIME SYMPTOMS

1. Do you snore?
   - ☐ Yes (1)
   - ☐ No (0) (Skip to question 5.)
   - ☐ Don't know/refused (0)
2. If you snore, your snoring is:
   - ☐ Slightly louder than breathing (0)
   - ☐ As loud as talking (0)
   - ☐ Louder than talking (0)
   - ☐ Very loud; can be heard in adjacent rooms (1)
   - ☐ Don't know/refused (0)
3. How often do you snore?
   - ☐ Nearly every day (1)
   - ☐ 3 to 4 nights a week (1)
   - ☐ 1 to 2 nights a week (0)
   - ☐ 1 to 2 nights a month (0)
   - ☐ Never or nearly never/don't know (0)
4. Has your snoring ever bothered other people?
   - ☐ Yes (1)
   - ☐ No/don't know/refused (0)
5. Has anyone noticed that you quit breathing during your sleep?
   - ☐ Nearly every day (2)
   - ☐ 3 to 4 times a week (2)
   - ☐ 1 to 2 times a week (0)
   - ☐ 1 to 2 times a month (0)
   - ☐ Never or nearly never/don't know/refused (0)

TOTAL POINTS FOR **SECTION 1:**__________
If **greater than or equal to 2** this section is **Positive**

SECTION 2: DAYTIME SYMPTOMS

6. How often do you feel tired or fatigued after your sleep?
   - ☐ Nearly every day (1)
   - ☐ 3 to 4 times a week (1)
   - ☐ 1 to 2 times a week (0)
   - ☐ 1 to 2 times a month (0)
   - ☐ Never or nearly never/don't know/refused (0)
7. During your wake time, do you feel tired, fatigued, or not up to par?
   - ☐ Nearly every day (1)
   - ☐ 3 to 4 times a week (1)
   - ☐ 1 to 2 times a week (0)
   - ☐ 1 to 2 times a month (0)
   - ☐ Never or nearly never/don't know/refused (0)
8. Have you ever nodded off or fallen asleep while driving a vehicle?
   - ☐ Yes (1)
   - ☐ No/don't know/refused (0)
9. If yes, how often does it occur?
   - ☐ Nearly every day (1)
   - ☐ 3 to 4 times a week (1)
   - ☐ 1 to 2 times a week (0)
   - ☐ 1 to 2 times a month (0)
   - ☐ Never or nearly never/don't know/refused (0)

TOTAL POINTS FOR **SECTION 2:**__________
If **greater than or equal to 2** this section is **Positive**

SECTION 3: COMORBIDITIES

10. Do you have high blood pressure?
    - ☐ Yes (1)
    - ☐ No/don't know/refused (0)
11. BMI: __________kg/m^2
    - ☐ greater than 30kg/m^2 (1)
    - ☐ less than or equal to 30kg/m^2 (0)

TOTAL POINTS FOR **SECTION 3:**__________
If **greater than or equal to 1** this section is **Positive**

ADDITIONAL INFORMATION:
Do you choke or gasp most nights? ☐ Yes ☐ No
Handedness: ☐ Left ☐ Right Neck Circumference:________cm

SCORING: IF THREE SECTIONS ARE POSITIVE OR IF TWO SECTIONS ARE POSITIVE PLUS THE PATIENT'S NECK CIRCUMFERENCE IS GREATER THAN 40 CM, THEN THE PATIENT IS AT HIGH-RISK FOR OBSTRUCTIVE SLEEP APNEA
- ☐ **NOT HIGH-RISK FOR OSA**
- ☐ **HIGH-RISK FOR OSA**

Clinician: ______________________ (SIGNATURE REQUIRED) ______________________ (PRINTED NAME REQUIRED) Date/Time:__________________

DO NOT WRITE BELOW THIS LINE

BJ 7-3343-2030

ORIGINAL - MEDICAL RECORDS
COPY - DEPARTMENT