The Sleep Apnea Center of Novi

Sleep Apnea Risk Assessment

ProSomnus Sleep Technologies

☐ M ☐ F ☐ O

Patient Name *Gender* *DOB* / /

Address *City* *State* Zip

Cell Phone *Email*

Medical Insurance Company *How did you hear about our office?*

Referring Physician's Name *Physician's Phone* *Physician's Location (City)*

Patient Sleepiness Scale (Risk Factors): Please check all that apply

		Pt	*Additional comments below*
1. I have been told I stop breathing while asleep	☐	4	
2. I have fallen asleep or nodded off while driving	☐	3	
3. I've woken up with shortness of breath/gasping or my heart racing	☐	3	
4. I feel excessively sleepy or fatigued during the day/ upon waking	☐	2	
5. I snore or have been told that I snore	☐	2	
6. I have had weight gain and found it difficult to lose	☐	2	
7. I have been diagnosed with high blood pressure (Hypertension)	☐	2	
8. It takes me less than 10 minutes to fall asleep	☐	2	
9. I wake up more than 1 time per night	☐	2	
10. I wake up with headaches	☐	2	

Total points from above: _____ Risk Level Score: ☐ **Low:** *0-4* ☐ **Moderate:** *4-6* ☐ **High:** *6-8* ☐ **Severe:** *8+*

Patient Health History (Signs & Symptoms): Please check all that apply

- ☐ Brain Fog
- ☐ Depression / Anxiety
- ☐ Smoker / Drinker
- ☐ Memory Loss
- ☐ Irritability / Moodiness
- ☐ Wake Up with Dry Mouth
- ☐ Sinus / Allergy Issues
- ☐ Previous Diagnosis of OSA
- ☐ Family History of Sleep Apnea
- ☐ Family History of Stroke
- ☐ Family History of Heart Disease
- ☐ Acid Reflux / GERD
- ☐ Sexual Dysfunction
- ☐ Diabetes
- ☐ Deviated Septum
- ☐ Grind Teeth / Bruxism

Patient Signature: _____ **Date:** _____

I authorize this practice to have and release my medical information for the purpose of the coordination of care

Office staff will complete the form below

- ☐ BMI > 30
- ☐ Narrow upper arch
- ☐ Visual airway obstruction
- ☐ Large/scalloped tongue
- ☐ Neck size: Male ≥ 16.5" or Female ≥ 16"

Occlusion _____

' " **Height** lbs **Weight** **Mallampati**

inches **Neck Size** **Blood Pressure** **Heart Rate**

Notes:

Married / Single Sleeps Alone Y / N Children Y / N

Patient chart notes reviewed and approved by: _____ **Date:** _____

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