SSM Health Sleep Disorders Center

400 N Pleasant Centralia, IL 62801

Fully Accredited by the American Academy of Sleep Medicine

Home Sleep Test (HST) Questionnaire

Date:_____ Technician:_____

Name:_____ Height _____ft ___in Weight _____

Referring MD:_____ Reason for Testing:_____

_____

Allergies: _____

Medications including over-the-counter: _____

_____

_____

Tobacco Use Yes/No ___Packs/Day Alcohol Use Yes/No Amount daily ____ weekly ____

Shift Worker Yes/No Work Hours _____ Claustrophobic Yes/No

Tonsillectomy Yes/No ENT Surgery Yes/No LaserUvuloplasty Yes/No

Please circle if you are being treated or have been diagnosed with the following:

High Blood Pressure / Heart Disease / Diabetes / Stroke / Depression / COPD /

Excessive Daytime Sleepiness / Asthma

Previous Sleep Study Yes/No Location _____ Date: _____

On CPAP Yes/No CPAP Setting _____ Result of Previous Study _____

_____

How did you find out about our Sleep Disorder Center?

My Doctor / Newspaper / Health Fair / Radio / Friend

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S T O P - BANG SCORING MODEL (OSA)

Snoring

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?

Yes / No

Tired

Do you often feel tired, fatigued, or sleepy during the daytime?

Yes / No

Observed

Has anyone observed you stop breathing during your sleep?

Yes / No

Blood Pressure

Do you have or are you being treated for high blood pressure?

Yes / No

BANG Questions

BMI - BMI more than 35?

Yes / No

Age -- Age over 50 year old?

Yes / No

Neck Circumference – greater than 40 cm?

Yes / No

Gender - Gender Male?

Yes / No

Total Yes _____

A Score of 3 or more is highly suggestive of OSA