WATONGA DENTAL

Patient Name: _____ Phone Number: _____
Screening Date: _____

Snoring?

Yes ○ No ○ Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?

Tired?

Yes ○ No ○ Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?

Yes ○ No ○ **O**bserved?

Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep?

Yes ○ No ○ **P**ressure?

Do you have or are being treated for **High Blood Pressure**?

Yes ○ No ○ **B**ody Mass Index more than 35 kg/m^2?

$$\text{BMI} = \frac{weight(\text{lb})}{height^2(\text{in}^2)} \times 703$$

Yes ○ No ○ **A**ge older than 50 year old?

Neck size large? (Measured around Adams apple)

Yes ○ No ○ For male, is your shirt collar 17 inches/43 cm or larger?
For female, is your shirt collar 16 inches/41 cm or larger?

Yes ○ No ○ **G**ender = Male?