Screening for OBSTRUCTIVE SLEEP APNEA
STOP BANG Questionnaire

Patient Name: _____ Date of Birth: _____

***Have you been previously diagnosed with Sleep Apnea?
If yes, you do not need to fill out this form***

This short questionnaire will help your physician to assess your risk for possible sleep apnea. Sleep apnea is a condition where your breathing may pause of stop for a time while you are sleeping. Sleep apnea may put you at an increase risk for breathing problems after surgery. If you are at risk, your physician may send you to a sleep specialist prior to surgery to further evaluate your risk for sleep apnea

Answer the following questions to find out if you are at risk for Obstructive Sleep Apnea:

STOP

S (snore) Have you been told that you snore? YES ☐ NO ☐

T (tired) Are you often tired during the day? YES ☐ NO ☐

O (obstruction) Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep? YES ☐ NO ☐

P (pressure) Do you have high blood pressure or on medication to control high blood pressure? YES ☐ NO ☐

*If you answered **YES** to two or more questions on the STOP portion you are at risk for Obstructive Sleep Apnea. It is recommended that you contact your primary care provider to discuss a possible sleep disorder.*
To find out if you are at moderate to severe risk of Obstructive Sleep Apnea, complete the BANG questions below.

BANG

B (BMI) Is your body mass index greater than 28? YES ☐ NO ☐

A (age) Are you 50 years old or older? YES ☐ NO ☐

N (neck) Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches. YES ☐ NO ☐

G (gender) Are you a male? YES ☐ NO ☐

*The more questions you answer **YES** to on the BANG portion, the greater your risk of having moderate to severe Obstructive Sleep Apnea.*

Chung F. (2008). STOP Questionnaire: A Tool to Screen Patients for Obstructive Sleep Apnea. *The American Society of Anesthesiologists, Inc.* 108:812-21.

NAME ☐ Mr. ☐ Ms. ☐ Dr. ☐ Mrs. ☐ Miss _____ (Last) _____ (First) _____ (Middle)

HOME ADDRESS _____ POSTAL CODE _____

EMAIL _____ DATE OF BIRTH: M _____ D _____ YR _____

TELEPHONE: HOME _____ CELL _____

BUSINESS _____

PERSON RESPONSIBLE FOR ACCOUNT _____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

PERSON TO NOTIFY IN EMERGENCY _____ PHONE _____

PRIMARY DENTAL INSURANCE

Subscriber's Name: _____ D.O.B. _____

Relationship to Subscriber _____ Ins. yr. end/Calendar yr. _____

Ins. Co. _____

Grp./Ind. policy No. _____ I.D./Cert. No. _____

Employer _____

SECONDARY DENTAL INSURANCE

Subscriber's Name: _____ D.O.B. _____

Relationship to Subscriber _____ Ins. yr. end/Calendar yr. _____

Ins. Co. _____

Grp./Ind. policy No. _____ I.D./Cert. No. _____

Employer _____

The following information is necessary in order that the dentist may thoroughly diagnose any condition and give you personal attention. You must be accurate for your health's sake. This information is confidential.

MEDICAL HISTORY

1. Date of your last medical check up _____
2. Have you ever been hospitalized for any illness or operations? Yes No
   If yes, why? _____
3. Height _____ Weight _____
4. Circle any of the following which you have had or have at present:

Heart Attack/Disease	Low/High Blood Pressure	Tuberculosis	Hepatitis A / B / C	Spells
Congenital Heart Lesions	Rheumatic/Scarlet Fever	Asthma	Liver Disease	Bruise Easily
Angina Pectoris	Artificial Joint	Diabetes	Blood Transfusion	Gastrointestinal Disorder
Heart Surgery	Anemia	Thyroid Disease	Drug/Alcohol Abuse	Migraines
Heart Pacemaker	Stroke	Radiation Therapy	Hemophilia or Bleeding Disorders	Creutzfeldt -Jakob Disease
Artificial Heart Valve	Kidney Disease	Chemotherapy	Epilepsy or Seizures	Other _____
Mitral Valve Prolapse	Ulcers	Leukemia	Growth/Tumor	_____
Heart Murmur	Emphysema	Cortisone Therapy	Mental/Nervous Disorder	
	Chronic Bronchitis	Glaucoma	Fainting/Dizzy	
		HIV+/AIDS		

5. Have you ever been advised by your doctor to take antibiotics prior to dental treatment? Yes No
6. Are you currently taking any medication, nonprescription drugs or herbal supplements of any kind? Yes No
   _____
7. Do you have any allergies? If so, please list _____
   medication ____ latex/rubber _____ hay fever/foods, etc _____ anesthetic _____

NOTES / MED CONSULT

PATIENT INFORMATION

8. Have you ever experienced allergic reaction (itching, rash, swelling or wheezing) to codeine, aspirin, penicillin, local anaesthetic (dental freezing) or other? Yes No
9. Have you ever had any excessive bleeding requiring treatment? _____ Yes No
10. Do you get chest pains upon exertion or shortness of breath after mild exercise? _____ Yes No
11. Do you get swelling of your ankles or have difficulty lying flat on your back? _____ Yes No
12. Do you use controlled substances (marijuana, cocaine, barbiturates, other)? _____ Yes No
13. Do you smoke/chew tobacco? If so, how much? _____ Yes No
14. WOMEN: Are you pregnant? Expected delivery date _____ Yes No
    Are you using birth control pills? _____ Yes No
15. Do you often feel sleepy or tired during the day, even after a full nights rest? Yes No
16. Do you snore? Yes No
17. Do you have a CPAP? Yes No
    If so, do you use it regularly? Yes No
18. Do you have sleep apnea? Yes No
19. Are you feeling ill at all today? Yes No
20. Is there anything special about your medical history or physical condition that you feel we should know? If yes, what? Yes No

_____

DENTAL HISTORY

1. What concerns you most about your dental health? _____
2. Do you feel nervous about having dental work done? _____ Yes No
3. Did you have a bad dental experience in the past? If so, what? _____ Yes No
4. Date of your last dental check up _____ Dentist _____
5. Do your gums bleed or hurt? _____ Yes No
6. Do you clench or grind your teeth? _____ Yes No
7. Do you have a history of TMJ problems? _____ Yes No
8. Have you ever had sedation at a dental appointment? _____ Yes No
9. Do you have sensitive teeth? _____ Yes No
10. Would you like to improve your smile? _____ Yes No
11. What changes would you like to have done on your smile and teeth? _____

_____

To the best of my knowledge, all of the proceeding information is accurate and I will advise this office of any future changes. I authorize the doctor and/or staff to perform diagnostic and treatment procedures as required for proper dental care. I also authorize the release of personal information for the purpose of evaluation and claiming insurance or other benefits and also to other health care providers for consultation or treatment. I understand I am financially responsible for fees associated with the procedures.

_____ _____

Patient Signature Date
(If patient is under 18, Guardian signature)

PERSONAL INFORMATION POLICY

We are committed to protecting the privacy of our client's personal information and to utilize all personal information in a responsible and professional manner. This document is a summary of some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our clients such as names, home addresses, and work addresses, home telephone numbers, work telephone numbers, and e-mail addresses. (Collectively referred to as "Contact Information"). Contact information is collected and used for the following purposes:

- To open and update client files.
- To invoice clients for dental services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement from third-party health benefit providers and insurance companies.
- To send reminders to clients concerning the need for further dental examination or treatment.
- To send clients informational material about our dental practice.

Contact information is disclosed to third party health benefit providers and insurance companies where the client has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the client's behalf.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our clients about their health history, their family health history, physical condition, and dental treatments. (Collectively referred to as "Medical Information"). Client's Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Client's Medical Information is disclosed:

- To third party health providers and insurance companies where the client has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on their behalf.
- To other dentists and dental specialists, where we are seeking a second opinion and the client has consented to us obtaining the second opinion.
- To other dentists and dental specialists where those dentists have asked us, with the consent of the client, to provide a second opinion.
- To other health care professionals such as physicians, if the client, with their consent, has been referred to us to the other health care professional for either a second opinion or treatment.

Qualified potential purchasers may be granted access as part of the due diligence process to client information in order to verify important information if we are considering selling. If this occurs, we will take steps to ensure that the prospective purchaser (who is also governed under the Privacy Act) safeguards all personal information.
Dentists are regulated by the Alberta Dental Association and College, which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

I consent to the collection, use and disclosure of my personal information as set out above.

Signature of Client/Guardian	Client Name (Print)	Date