SASS/ Medication List

DATE: ____________________________ NAME: ____

Please LIST THE MEDICATIONS you are currently taking:

MEDICATION NAME	DOSE	QTY & FREQUENCY

ALLERGIC TO: ____

PREFERRED PHARMACY: _____________________________LOCATION: ____________________________

Quick Screen for Sleep Apnea
(Sleep Apnea Screen Score)

Do you have the following symptoms or have you been diagnosed to have the following medical conditions? If Yes, transfer the exact number shown over to "Your Score"

	Points	"Your Score"
➢ Stop breathing in your sleep	10	____________
➢ Loud snoring	9	____________
➢ Excessive daytime sleepiness	4	____________
➢ Chronic fatigue / Depression	1	____________
➢ Frequent headaches	1	____________
➢ Hypertension (high blood pressure)	1	____________
➢ Congestive heart failure	1	____________
➢ Stroke	1	____________
➢ Neck collar size	1	____________

(you will be measured in the office) ☐ Male > 17" ☐ Female > 16"

TOTAL SCORE ____________

Your total score of 10 or more indicates you may have sleep apnea.

Stanislaus Sleep Disorders Center (209) 522-8881