website: www.roninss.com
email: info@roninss.com
phone/fax: (800) 953-1547

3707 East Southern Ave
PMB #1329
Mesa, AZ 85206

Sleep Patient Information Form

Patient Demographic Information			
Patient Name:		**AGE:**	
Current Address:		**DOB:**	
City:		**Gender:**	
State:		**Primary Phone:**	
Zip Code:		**Primary email:**	

Patient Sleep Screening			
Height:		**Epworth Sleepiness Scale Score**	
Weight:		**STOP/BANG Score**	
BMI:		**FOSQ-10 Questionnaire Score**	
Usual Bedtime:		**Usual Wake Time:**	
Average Sleep Time:		**Desired Sleep Time:**	

Ronin Sleep Solutions Screening Questions (RSSSQ): (Patients Answer Yes/No to each of the following questions)

Do you snore loud enough others commented?		Does your breathing shallow/stop when sleeping?	
Do you feel rested when waking?		Do you take 20 min or more to fall asleep?	
Are you restless and twitch or shake legs in wake?		Are you restless and move legs/body in sleep?	
Do you keep a regular sleep schedule?		Do you wake at a set time each day?	
Do you feel you dream in your sleep?		Do you feel you get deep sleep regularly?	
Have you been experiencing depression/anxiety?		Are you dealing with other medical issues?	
Do you ever feel paralyzed when waking up?		Do you ever feel paralyzed while falling asleep?	
When excited do you ever collapse/feel paralyzed?		Do you have Hypertension or Heart problems?	
Do you use a quiet environment for sleep?		Do pets or children co-sleep in the room or bed?	
Do you use a sound machine/app to sleep?		Do you sleep more than 7 hours per night?	
Do you exercise at least mildly 3 times a week?		Do you have a consistent diet of healthy foods?	
Do you take any medications to assist sleep?		Do others complain/comment about your sleep?	

I am interested in the following appointment types:

	I wish to complete a sleep screening with the sleep technologist to review with my doctor and get tested.
	I have current problems with my sleep treatment (CPAP, Dental Appliance, Inspire, etc.) and have questions.
	I have a report from a previous or recent study I don't understand and need assistance to review.
	I understand that the sleep technologist will gather information and prepare documentation for me to discuss with the sleep physician. The sleep Technologist can not give medical advice, prescribe or discontinue medical treatments, prescribe/discontinue medications, but serves a guide to get you the sleep care you need from qualified medical professionals. Ronin Sleep Solutions recommends patients always follow with a Board-Certified Sleep Specialist for their sleep care.

website: www.roninss.com
email: info@roninss.com
phone/fax: (800) 953-1547

RONIN SLEEP SOLUTIONS

3707 East Southern Ave
PMB #1329
Mesa, AZ 85206

Stop-Bang OSA Risk Assessment

	Snoring	Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?
	Tired	Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?
	Observed	Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep ?
	Pressure	Do you have or are being treated for **High Blood Pressure** ?
	Body Mass	**Do you have a body mass index more than 35?**
	Age	**Are you currently older than 50 ?**
	Neck size	**Do you have a large neck circumference?**
	Gender	**Are you a Male? (Males have a higher risk and neck size on average.)**

OSA - Low Risk : Yes to 0 - 2 questions | OSA - Intermediate Risk : Yes to 3 - 4 questions | OSA - High Risk : Yes to 5 - 8 questions
High Risk also if Yes to 2 or more of 4 STOP questions + male gender or High Risk also Yes to 2 or more of 4 STOP questions + BMI > 35kg/m^2
High Risk also Yes to 2 or more of 4 STOP questions + neck circumference 16 inches / 40cm

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in the past few months. Even if you have not done some of these things recently, try to work out how they would have affected you. Choose the most appropriate number for each situation.

0 = Would never fall asleep 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

Sitting and reading a book.	
Watching content on TV/Tablet/Phone.	
Sitting in a public place (i.e., theater or a meeting).	
As a passenger in a car for an hour without a break.	
Lying down to rest in the afternoon when circumstances permit.	
Sitting and talking to someone.	
Sitting quietly after a lunch without alcohol.	
In a car, while stopped for a few minutes in traffic.	
Total Score	

Interpretation: 0-7:It is unlikely that you are abnormally sleepy. 8-9:You have an average amount of daytime sleepiness. 10-15:You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention. 16-24:You are excessively sleepy and should consider seeking medical attention

website: www.roninss.com
email: info@roninss.com
phone/fax: (800) 953-1547

3707 East Southern Ave
PMB #1329
Mesa, AZ 85206

FOSQ-10 Sleep Questionnaire

Instructions

Some people have difficulty performing everyday activities when they feel tired or sleepy. The purpose of this questionnaire is to find out if you generally have difficulty carrying out certain activities because you are too sleepy or tired. In this questionnaire, when the words "sleepy" or "tired" are used, it means the feeling that you can't keep your eyes open, your head is droopy, that you want to "nod off", or that you feel the urge to take a nap. These words do not refer to the tired or fatigued feeling you may have after you have exercised.

Directions

Please select the most appropriate answer to each question. Select only one answer for each question. Please try to be as accurate as possible. All information will be kept confidential.

1	Do you have difficulty concentrating on the things you do because you are sleeping or tired?	
2	Do you generally have difficulty remembering things because you are sleepy or tired?	
3	Do you have difficulty finishing a meal because you become sleepy or tired?	
4	Do you have difficulty working on a hobby (for example sewing, collecting, gardening) because you are sleepy or tired?	
5	Do you have difficulty doing work around the house (for example, cleaning house, doing laundry, taking out the trash, repair work) because you are sleepy or tired?	
6	Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?	
7	Do you have difficulty operating a motor vehicle for long distances (more than 100 miles) because you become sleepy or tired?	
8	Do you have difficulty getting things done because you are too sleepy or tired to drive or take public transportation?	
9	Do you have difficulty taking care of financial affairs and doing paperwork (for example writing checks, paying bills, keeping financial records, filling out tax forms, etc.) because you are sleepy or tired?	
10	Do you have difficulty performing employed or volunteer work because you are sleepy or tired?	
	Add the Number scores for a Total and enter in this Field:	

Source: Weaver (1996) Functional Outcomes of Sleep Questionnaire (FOSQ) **FOSQ-10 Score**

I have reviewed and completed all three pages to the best of my knowledge.

Type name above for Signature