Sleep Apnea Screening

FATIGUE SEVERITY SCALE (FSS)

Date _____ Name _____

Please circle the number between 1 and 7 which you feel best fits the following statements. This refers to your usual way of life within the last week. 1 indicates "strongly disagree" and 7 indicates "strongly agree."

Read and circle a number.	Strongly Disagree → Strongly Agree						
1. My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
2. Exercise brings on my fatigue.	1	2	3	4	5	6	7
3. I am easily fatigued.	1	2	3	4	5	6	7
4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
8. Fatigue is among my most disabling symptoms.	1	2	3	4	5	6	7
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7

Answer the following questions:

S – Do you Snore? Yes | No

T– Do you feel Tired, fatigued or sleepy during daytime? Yes | No

O– Has anyone Observed you stop breathing during your sleep? Yes | No

P– Do you have or are you being treated for high blood Pressure? Yes | No

B- BMI (Body Mass Index-approximately 30 lbs overweight) Yes | No

A- Age > 50 yr Yes | No

N- Neck circumference > 15.75" (40 cm) Yes | No

G- Gender: male Yes | No

If you answered YES to two or more questions on the STOP BANG questionnaire you are at high risk for Obstructive Sleep Apnea. It is recommended that you seek expert medical advice.