

Sleep Apnea Questionnaire

\*Please fill out form even if you do not feel that it does not apply\*

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a sleep study done? \_\_\_\_\_\_\_\_\_\_\_\_\_ If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have someone observing you while you sleep? \_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Answer to the best of your ability | Yes | Seldom | Never | Not Sure |
| Do you snore? |  |  |  |  |
| If you do snore, does it awaken your bed partner? |  |  |  |  |
| Do you doze off while watching TV, driving, reading or performing daily activities? |  |  |  |  |
| Have you or your bed partner observed that you stop breathing or gasp for breath while sleeping? |  |  |  |  |
| Do you ever wake up out of breath or choking? |  |  |  |  |
| Are you a restless sleeper? |  |  |  |  |
| Do you have joint aches? |  |  |  |  |
| Do you have backaches? |  |  |  |  |
| Do you have headaches? If so, how often? |  |  |  |  |
| Do you have indigestion or acid reflux? |  |  |  |  |
| Do you have or have you ever had high blood pressure? |  |  |  |  |
| Have you ever had high cholesterol? |  |  |  |  |
| Do you have or have you ever had heart problems? |  |  |  |  |
| Do you have night sweats? |  |  |  |  |

Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_