Sleep Apnea Questionnaire

Name _____

Date _____

Height _____ inches **Weight** _____ lb

Age _____

Male/Female

1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?

   Yes No

2. Do you often feel tired, fatigued, or sleepy during the daytime?

   Yes No

3. Has anyone observed you stop breathing during your sleep?

   Yes No

4. Do you have or are you being treated for high blood pressure?

   Yes No

5. Age over 50 yr old?

   Yes No

6. Gender male?

   Yes No

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BMI _____

Neck Circumference _____ cm

7. BMI more than 35 kg/m^2?

   Yes No

8. Neck circumference greater than 40 cm?

   Yes No

High risk of OSA: Answering yes to three or more items

Low risk of OSA: Answering yes to less than three items