

Sleep Screening Questionnaire



*Required Fields

Sleep Screening Questionnaire

Patient First Name:*

Patient Middle Name:

Patient Last Name:*

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

- Yes
- No

Do you often feel tired, fatigued or sleepy during daytime hours?

- Yes
- No

Has anyone ever observed you stop breathing during your sleep?

- Yes
- No

Are you now being or have you been treated for high blood pressure?

- Yes
- No

Is your BMI greater than 25?

- Yes
- No

HEIGHT:

WEIGHT:

BMI:

Are you over 50 years old?

- Yes
- No

Is your neck circumference more than 16 inches?

- Yes
- No

What is your Gender?

- Male
- Female
- Prefer not to mention

Have you ever had a sleep study?

- Yes
- No

When?

Do you wear, or have you worn, a CPAP for sleep apnea?

- Yes
- No

****If you answered YES to more than 3 of these questions you may be at higher risk for obstructive sleep apnea, and further evaluation may be indicated.**