Adult Sleep & Breathing Questionnaire

Date: _____

Patient 's Name: _____

Patient's Date of Birth: _____ Age: _____

Male _____ Female _____

Have you ever had a sleep test administered? _____ yes _____no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? _____yes _____no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? _____yes _____no

Are you happy with your CPAP or Sleep Appliance? _____yes _____no

If you are not happy - why? _____

_____

_____

How often do you get out of bed to use the restroom during the night? _____

	Yes	No
Do you usually wake feeling tired and unrested?	☐	☐
Do you habitually snore?	☐	☐
Have you been diagnosed with Hypertension/High Blood Pressure?	☐	☐
Do you often suffer from waking headaches?	☐	☐
Do you regularly experience daytime drowsiness or fatigue?	☐	☐
Do you have blocked nasal passages?	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐
Do you ever wake up choking or gasping?	☐	☐
Do you grind your teeth while sleeping?	☐	☐
Is your neck circumference greater than 40 cm/ 15.75" ?	☐	☐
Is your Body Mass Index (BMI) more than 35?	☐	☐

BMI Formula BMI = (your weight in pounds X 703)

_____

(your height in inches X your height in inches)