# 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:______________________________________________________________________

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