

**Sleep Study Questionnaire**

Patient Name:

Age:

Gender: M F Height: **\_\_\_\_\_\_\_\_\_\_\_** Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_ BMI: \_\_\_\_\_\_\_\_\_\_\_\_\_

1a. Do you snore? Yes No

1b. If yes, how often do you snore? Always Frequently Sometimes

**\*1c. If yes, your snoring is best described as? Very loud, can be heard in adjacent rooms As loud as talking Slightly louder than breathing**

1d. If yes, has your snoring ever bothered other people? Yes No

**2a. Do you quit breathing during your sleep?** **Yes No**

2b. If yes, how often does this occur? Always Frequently Sometimes

3. How often do you feel tired or fatigued after your sleep? Always Frequently Sometimes Never

**\*4. During your wake time, do you feel tired, fatigued, or not up to par? Always Frequently Sometimes Never**

5. Have you ever nodded off or fallen asleep while driving a vehicle? Always Frequently Sometimes Never

**\*6. Do you have high blood pressure?** **Yes No**

For clinic staff:

**\*7. Is the patient’s BMI greater than 35 kg / m2? Yes No**

**\*8. Is the patient’s age over 50 years old?** **Yes No**

**\*9. Is the patient’s neck circumference greater than 16 inches (40cm)? Yes No**

**\*10. Is the patient a male? Yes No**

Total Score: \_\_\_\_\_\_\_\_\_\_\_\_

If answered “Yes” to 0-2 questions = Low Risk of OSA

If answered “Yes” to 3-4 questions = Moderate Risk of OSA

If answered “Yes” to 5-8 questions = High Risk of OSA