

Adult Sleep & Breathing Questionnaire

Date:					
Patient 's Name:					
Patient's Date of Birth:		_ Age:			
Male Female _					
Have you ever had a sleep test ad	ministered? y	esno			
If yes - when did you have your la	st sleep test?				
Have you been diagnosed with Sle	eep 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?	yesno			
If you are not happy - why?					
How often do you get out of bed	to use the restroom dur	ing 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" ?					
s your Body Mass Index (BMI) more than 35?					
BMI Formula	BMI =	(your weight in pou	nds X 703)		

(your height in inches X your height in inches)