SLEEP APNEA QUESTIONNAIRE

Patient Name _____ DOB _____ Date _____

This questionnaire was developed based upon the published findings of the American Academy of Sleep Medicine (AASM). The purpose of this questionnaire is to aid a qualified medical professional in identifying possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.

Y / N	8	Have you ever been told you stop breathing while asleep?
Y / N	6	Have you ever fallen asleep or nodded off while driving?
Y / N	6	Have you ever woken up suddenly with shortness of breath, gasping, or heart racing?
Y / N	4	Do you feel excessively sleepy during the day?
Y / N	4	Do you snore, or have you ever been told you snore?
Y / N	2	Have you had weight gain and found it difficult to lose?
Y / N	2	Have you taken medication for, or been diagnosed with high blood pressure?
Y / N	3	Do you kick or jerk your legs while sleeping?
Y / N	3	Do you feel burning, tingling or crawling sensation in your legs when you wake up?
Y / N	3	Do you wake up with headaches during the night or in the morning?
Y / N	4	Do you have trouble falling asleep?
Y / N	4	Do you have trouble staying asleep once you fall asleep?
TOTAL SCORE		

FOR CLINICAL USE ONLY

LOW	MODERATE	HIGH	SEVERE
0 - 7	8 - 11	12 - 15	16+

Visual Indications:

☐ Enlarged/Scalloped Tongue ☐ Retruded Lower Jaw ☐ High Arching Hard Palate ☐ Bruxism

☐ Gastro Esophageal Reflux ☐ Enlarged Tonsils ☐ Mouth Breather

Have you ever been diagnosed with a sleep disorder? ☐ Yes ☐ No

Are you using a CPAP machine? ☐ Yes ☐ No

Notes:

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