Obstructive Sleep Apnea Screening

Patient Name _____ Date of Birth_____

	YES	NO
Has anyone told you that you snore loudly?		
Are you male?		
Are you sleepy or do you doze off during the day?		
Are you 50 years or older?		
Has anyone told you that you stop breathing during sleep?		
Do you have high blood pressure?		
What is your height? _____ And your Weight? _____		

- ☐ I have been previously diagnosed with OSA and am regularly using my CPAP or other OSA therapy
- ☐ I have been previously diagnosed with OSA and am not using my CPAP or other therapy regularly
- ☐ Others in my family have been diagnosed with OSA
- ☐ I have a pacemaker

_____ _____ _____

Patient signature **Date**

_____

Staff Only:

Patient Score _____ Scored by:_____

BMI>30 = YES

** All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting doctor and any other practitioner that you specify.*