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SLEEP APNEA QUESTIONNAIRE

- 1 in 3 Americans have undiagnosed sleep disorders
- Over 40 million Americans are chronically ill with various sleep disorders
- 40% of Americans report difficulty either falling asleep or staying asleep
- It is estimated that 90% of the population of obstructive sleep apnea has not been diagnosed

NAME_________________________________INSURANCE________________________PHONE__________________

THIS QUESTIONNAIRE WAS DEVELOPED BASED UPON PUBLISHED ARTICLES BY THE AMERICAN ACADEMY OF SLEEP MEDICINE

	CIRCLE ONE		
Have you been told that you stop breathing while you sleep?	Yes	No	8
Have you ever fallen asleep or nodded off while driving?	Yes	No	6
Do you awaken suddenly with shortness of breath, gasping or with your heart racing?	Yes	No	6
Do you feel excessively sleep during the day?	Yes	No	4
Has anyone ever told you that you snore while are sleeping?	Yes	No	4
Have you had weight gain and found it difficult to lose?	Yes	No	2
Have you taken medication for or been diagnosed with high blood pressure?	Yes	No	2
Do you kick or jerk your legs while sleeping?	Yes	No	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Yes	No	3
Do you wake up with headaches during the night or in the morning?	Yes	No	3
Do you have trouble falling asleep?	Yes	No	4
Do you have trouble staying asleep once you fall asleep?	Yes	No	4

Add the points together that you have answered “Yes”　　Score & Risk Factor: ________

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

PATIENT CONSENT

I hereby consent to the disclosure of my responses to the Sleep Apnea Questionnaire for the purpose of assisting in the diagnosis and treatment of a potential sleep disorder. I understand that as part of this organization’s treatment, payment or health care operations, it may become necessary to disclose to my protected health information to another entity, and I consent such disclosure for the permitted uses, including, but not limited to, disclosures via fax. I fully understand and accept the terms of this consent.

______________________________________　　_____________________
Patient Signature　　Date