

Sleep Apnea Questionnaire

- | | YES | NO |
|---|-------|-------|
| 1. Snore: Do you snore loudly? (Louder than talking or loud enough to be heard behind a closed door?) | _____ | _____ |
| 2. Tired: Do you often feel tired, fatigued or sleepy during daytime? | _____ | _____ |
| 3. Obstruction: Has anyone observed you stop breathing during your sleep? | _____ | _____ |
| 4. Pressure: Do you have or are you being treated for high blood pressure? | _____ | _____ |
| 5. BMI: Is your body mass index greater than 28? | _____ | _____ |
| 6. Age: Are you 50 years old or older? | _____ | _____ |
| 7. Neck: Are you a male with a neck circumference greater than 17 inches, Or a female with a neck circumference greater than 16 inches? | _____ | _____ |
| 8. Gender: Are you a male? | _____ | _____ |

