BARRINEAU D.D.S.
Family Dental Care & Wellness

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?	____	____