

Adult Sleep & Breathing Questionnaire

Date:					
Patient 's Name:					
Patient's Date of Birth:		Age:	_		
Male Female					
Have you ever had a sleep test adm	ninistered? yes	no			
If yes - when did you have your last	sleep test?				
Have you been diagnosed with Slee	ep Apnea?yes	no			
Do you currently use a CPAP or Sleep Appliance for Sleep Apnea?yes					
Are you happy with your CPAP or S	leep Appliance?	yesno			
If you are not happy - why?					
How often do you get out of bed to	use the restroom during	g the night?			
			Yes	No	
Do you usually wake feeling tired a	nd unrested?				
Do you habitually snore?					
Have you been diagnosed with Hyp	ertension/High Blood Pr	essure?			
Do you often suffer from waking headaches?					
Do you regularly experience daytime drowsiness or fatigue?					
Do you have blocked nasal passages?					
Has anyone observed you stop breathing during your sleep?					
Do you ever wake up choking or gasping?					
Do you grind your teeth while sleep	oing?				
Is your neck circumference greater	than 40 cm/ 15.75"?				
Is your Body Mass Index (BMI) mor	e than 35?				
BMI Formula	BMI =	vour weight in nour	nds X 703)		

(your height in inches X your height in inches)