

Name: _____
 Address: _____
 Height: _____ Weight: _____
 Age: _____ Male/Female: _____

Category 1

1. Do you snore?

- ☐ Yes
☐ No
☐ Don't know

If you snore:

2. Your snoring is?

- ☐ Slightly louder than breathing
☐ As loud as talking
☐ Louder than talking
☐ Very loud - can be heard in adjacent rooms

3. How often do you snore?

- ☐ Nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐ 1-2 times a month
☐ Never or nearly never

4. Has your snoring ever bothered other people?

- ☐ Yes
☐ No
☐ Don't know

5. Has anyone noticed that you quit breathing during your sleep?

- ☐ Nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐ 1-2 times a month
☐ Never or nearly never

Category 2

6. How often do you feel tired or fatigued after your sleep?

- ☐ Nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐ 1-2 times a month
☐ Never or nearly never

7. During your waking time, do you feel tired, fatigued or not up to par?

- ☐ Nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐ 1-2 times a month
☐ Never or nearly never

8. Have you ever nodded off or fall asleep while driving a vehicle?

- ☐ Yes
☐ No

If yes, how often does this occur?

- ☐ Nearly every day
☐ 3-4 times a week
☐ 1-2 times a week
☐ 1-2 times a month
☐ Never or nearly never

Category 3

9. Do you have high blood pressure?

- ☐ Yes
☐ No
☐ Don't know

10. BMI >30

- ☐ Yes
☐ No

Scoring questions:

Scoring categories:

Any answer in a white box is a positive response.

Category 1 is positive with 2 or more positive responses to question 1 - 5

Category 2 is positive with 2 or more positive responses to question 6 - 8

Category 3 is positive with 1 positive response to question 9 -10

Final results:

If 2 or more categories are positive, you have a high likelihood of sleep apnea.