Patient Questionnaire

Patient Name: ______________________________________ Date: ____/____ /____

	YES	NO
1) Do you snore?	☐	☐
2) Is snoring a problem for you?	☐	☐
3) Does your significant other snore?	☐	☐
4) Is snoring a problem for your relationship?	☐	☐

5) Do you have High Blood Pressure?	☐	☐
6) Are you on Blood Pressure Medicine?	☐	☐
7) Do you have Heart Disease?	☐	☐
8) Have you had a Heart Attack?	☐	☐
9) Have you had a Stroke?	☐	☐
10) Are you on Blood Thinners?	☐	☐
11) Do you have Gastric Reflux (GERD)?	☐	☐
12) Do you have Type II Diabetes?	☐	☐
13) Are you more than 30 lbs overweight?	☐	☐
14) Are you having trouble losing weight?	☐	☐
15) Have you been told you stop breathing when asleep?	☐	☐
16) Do you wake up exhausted in the morning?	☐	☐

SCORE Your Survey Results:
If you answered YES to any question for items 1 to 4. You (#3 =your significant other) need a Sleep Test.
If you answered YES to 2 or more questions for items 5 to16. You need a Sleep Test.

17) Have you ever been given a CPAP/APAP device?	☐	☐
18) If so, do you use it every night?	☐	☐
19) Are you comfortable and satisfied with your CPAP/APAP?	☐	☐

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