



# Adult Sleep & Breathing Questionnaire

Date: \_\_\_\_\_

Patient 's Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_

Have you ever had a sleep test administered? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes - when did you have your last sleep test? \_\_\_\_\_

Have you been diagnosed with Sleep Apnea? \_\_\_\_\_ yes \_\_\_\_\_ no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? \_\_\_\_\_ yes \_\_\_\_\_ no

Are you happy with your CPAP or Sleep Appliance? \_\_\_\_\_ yes \_\_\_\_\_ no

If you are not happy - why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How often do you get out of bed to use the restroom during the night? \_\_\_\_\_

	Yes	No
Do you usually wake feeling tired and unrested?	<input type="checkbox"/>	<input type="checkbox"/>
Do you habitually snore?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with Hypertension/High Blood Pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often suffer from waking headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Do you regularly experience daytime drowsiness or fatigue?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have blocked nasal passages?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone observed you stop breathing during your sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever wake up choking or gasping?	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind your teeth while sleeping?	<input type="checkbox"/>	<input type="checkbox"/>
Is your neck circumference greater than 40 cm/ 15.75" ?	<input type="checkbox"/>	<input type="checkbox"/>
Is your Body Mass Index (BMI) more than 35?	<input type="checkbox"/>	<input type="checkbox"/>

BMI Formula

BMI =

(your weight in pounds X 703)

\_\_\_\_\_  
(your height in inches X your height in inches)