Obstructive Sleep Apnea Screening Form

Patient Name : _____ Date : _____

DOB:_____ Height:_____Weight:_____ Gender:_____

Do you Snore? _____Yes _____No

Are you tired, fatigued or sleepy during the day? _____Yes _____No

Do you have high blood pressure? _____Yes _____No

Do you ever choke or gasp while you sleep? _____Yes _____No

Have you had an overnight sleep study? _____Yes _____No

Do you have a CPAP? _____Yes _____No

Do you use your CPAP every night? _____Yes _____No