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- **1 in 3 Americans have undiagnosed sleep disorders**
- **Over 40 million Americans are chronically ill with various sleep disorders**
- **40% of Americans report difficulty either falling asleep or staying asleep**
- **It is estimated that 90% of the population of obstructive sleep apnea has not been diagnosed**

Sleep Apnea Questionnaire

- Name: _____ Height _____ Weight _____
- Insurance: _____ Neck Size _____
- Phone: _____ BMI _____ Age _____

THIS QUESTIONNAIRE WAS DEVELOPED BASED UPON PUBLISHED ARTICLES BY THE AMERICAN ACADEMY OF SLEEP MEDICINE (A.A.S.M.)

		Points
Have you been told that you stop breathing while you sleep?	Yes ☐ No ☐	8
Have you ever fallen asleep or nodded off while driving?	Yes ☐ No ☐	6
Do you awaken suddenly with shortness of breath, gasping or with your heart racing?	Yes ☐ No ☐	6
Do you feel excessively sleepy during the day?	Yes ☐ No ☐	4
Has anyone ever told you that you snore while you are sleeping?	Yes ☐ No ☐	4
Have you had weight gain and found it difficult to lose?	Yes ☐ No ☐	2
Have you taken medication for or been diagnosed with high blood pressure?	Yes ☐ No ☐	2
Do you kick or jerk your legs while sleeping?	Yes ☐ No ☐	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Yes ☐ No ☐	3
Do you wake up with headaches during the night or in the morning?	Yes ☐ No ☐	3
Do you have trouble falling asleep?	Yes ☐ No ☐	4
Do you have trouble staying asleep once you fall asleep?	Yes ☐ No ☐	4

Add the points together that you have answered "Yes" **Score & Risk Factor:** _____

Low	**Moderate**	**High**	**Severe**
0-7	**8-11**	**12-15**	**16 +**

Patient Consent

I hereby consent to the disclosure of my responses to the sleep Apnea questionnaire for the purpose of assisting in the diagnosis and treatment of a potential sleep disorder.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose to my protected health information to another entity, and I consent such disclosure for the permitted uses, including, but not limited to, disclosures via fax. I fully understand and accept the terms to this consent.

_____ _____
Patient Signature Date