WWW.ISLEEPPROGRAM.COM
Tel. 888-929-SLEEP (7533)
Fax. 888-929-7537

Sleep Health Questionnaire

Name: ______________________________ **Date:** ____________________

Age:________ **Weight:** _________ **Sex: M / F** **Height:**__________________

1. Do you snore or have been told by someone that you snore? — Yes (2 pts) — No

2. Has anyone ever noticed that you quit breathing during your sleep? — Yes (3 pts) — No

3. Do you ever awaken with a sensation of gasping or choking? — Yes (3 pts) — No

4. Do you often feel tired or fatigued immediately after getting up from sleep? — Yes (1 pt) — No

5. During your waking time, do you often feel tired, fatigued or not up to par? — Yes (1 pt) — No

6. Have you, in the past 6 months, nodded off or fallen asleep in any situation(s) where you did not intend to? — Yes (1 pt) — No

7. Do you have (or are being treated for) high blood pressure? — Yes (1 pt) — No

Total Points:__________

Please add up the points from questions that were answered "yes". If the point total is greater than 2, the patient is a good candidate for a diagnostic sleep study.

0 - 2 = Lower risk of having Obstructive Sleep Apnea
3 - 4 = Moderate risk of having Obstructive Sleep Apnea
5 - 12 = High risk of having Obstructive Sleep Apnea

Este questionario utiliza porciones de los questionarios Berlin y Epworth ,los cuales son utilizados por la AASM como herramienta diagnostica para la Apnea Obstructiva del Sueño (OSA).