Sleep Disordered Breathing Screening Form

Patient Name:________________________________ Date of Birth:_____/ _____/ ________

*We have developed this self-scoring questionnaire as a guideline to help identify sleep disordered breathing problems. Please **check [√]** the appropriate box if you have experienced any of the symptom(s) on a regular basis. Your doctor will discuss these results with your during your visit.*

1. I have been told that I snore.	[ ]
2. I have been told that I stop breathing when I sleep, although I may have no recollection of this.	[ ]
3. I am always sleepy during the day even when I have slept throughout the night.	[ ]
4. I have high blood pressure.	[ ]
5. I have been told that I sleep restlessly. I am always "tossing" and "turning".	[ ]
6. I tend to sweat excessively during my sleep.	[ ]
7. I frequently awaken with headaches in the morning.	[ ]
8. I tend to fall asleep during inappropriate times.	[ ]
9. Others and/or I have noticed a change in my personality.	[ ]
10. I am overweight. Current Weight:	[ ]
Total Checked [√] Positive:	[ ]

SCORING: If you have **Marked 3 or MORE Boxes**, you show **symptoms of Sleep Apnea**, a sleep disorder that causes you to stop breathing during your sleep. If you are experiencing any of these symptoms ask your doctor if an overnight sleep study is needed.