Sleep Apnea Questionnaire

This questionnaire was developed based upon the published findings of the American Academy of Sleep Medicine (AASM). The purpose of this questionnaire is to aid a qualified medical professional in identifying possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.

Y / N 8 Have you ever been told you stop breathing while asleep?
Y / N 6 Have you ever fallen asleep or nodded off while driving?
Y / N 6 Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?
Y / N 4 Do you feel excessively sleepy during the day?
Y / N 4 Do you snore, or have you ever been told that you snore?
Y / N 2 Have you had weight gain and found it difficult to lose?
Y / N 2 Have you taken medication for, or been diagnosed with high blood pressure?
Y / N 3 Do you kick or jerk your legs while sleeping?
Y / N 3 Do you feel burning, tingling or crawling sensations in your legs when you wake up?
Y / N 3 Do you wake up with headaches during the night or in the morning?
Y / N 4 Do you have trouble falling asleep?
Y / N 4 Do you have trouble staying asleep once you fall asleep?

Total Score

FOR CLINICAL USE ONLY

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

Visual Indications
___ Enlarged/Scalloped Tongue   ___ Retruded Lower Jaw   ___ High Arching Hard Palate   ___ Bruxism
___ Gastoesophageal Reflux   ___ Enlarged Tonsils   ___ Mouth Breather

Have you ever been diagnosed with a sleep disorder?   ___ YES   ___ NO
Are you currently using a CPAP machine?   ___ YES   ___ NO (if yes) Do you use it every night?   ___ YES   ___ NO

Notes: