Screening for

Obstructive Sleep Apnea

Name _____ Date _____

MEDICAL HISTORY

Please check all that apply:

- ☐ Depression, irritability
- ☐ Morning headaches
- ☐ Memory and learning problems
- ☐ Trouble concentrating
- ☐ Mood swings, personality changes
- ☐ Chronic nasal congestion
- ☐ Family history of snoring or sleep apnea
- ☐ High blood pressure
- ☐ Stroke
- ☐ Heart disease
- ☐ Atrial fibrillation or other problems with your heart rhythm
- ☐ Type 2 diabetes
- ☐ Acid reflux
- ☐ Decreased sex drive

SLEEP HISTORY

Have you ever had a sleep study or been told to get one?	YES NO
Have you ever been diagnosed with a sleep disorder?	YES NO
Do you wake up in the morning feeling unrefreshed?	YES NO
Are you a restless sleeper?	YES NO
Do you catch yourself nodding off during the day (at times when you shouldn't be)?	YES NO
Does your bed partner sleep in another room because of your snoring?	YES NO
Do you wake up frequently to urinate during the night?	YES NO
Do you grind your teeth at night?	YES NO
Have you ever had jaw clicking/pain, tooth sensitivity, or been told you have TMD?	YES NO
Do you have a dry mouth or a sore throat when you wake up?	YES NO
Have you **ever** used a CPAP machine?	YES NO
Are you **currently** using a CPAP machine?	YES NO
If yes, do you use your CPAP less than 5 times per week?	YES NO
Have you tried CPAP and are looking for other treatment choices?	YES NO