Patient Name: ____________________________  
Date: ___________

**Sleep Apnea Risk Awareness Survey**

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had a sleep study done? ______ When? ______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you awaken more than once at night to urinate?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you snore?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your partner tell you that you stop breathing when you sleep?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you wake up gasping at night?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel “worse” when you wake up?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel sleepy during the day?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have high blood pressure?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you more than 30 pounds overweight?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you suffer from morning headaches?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your concentration, memory, or temper (irritability) been worsening?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>