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Patient Name:____________________________
Date:___________

Sleep Apnea Risk Awareness Survey

Have you every had a sleep study done?______When?________

	YES	NO
Do you awaken more than once at night to urinate?....................................	____	____
Do you snore?...	____	____
Does your partner tell you that you stop breathing when you sleep?...........	____	____
Do you wake up gasping at night?..	____	____
Do you feel "worse" when you wake up?...	____	____
Do you feel sleepy during the day?..	____	____
Do you have high blood pressure?..	____	____
Are you more than 30 pounds overweight?..	____	____
Do you suffer from morning headaches?...	____	____
Has your concentration, memory, or temper (irritability) been worsening?..	____	____