

OSA Questionnaire

Sleep Evaluation for Health Professionals



Please complete questions 1 thru 10 and give to your doctor for review.

1. Do you snore?

- Yes
- No
- Don't know

2. If you snore, is it:

- Very loud. Can be heard in other rooms.
- Louder than talking
- As loud as talking
- Slightly louder than breathing

3. How often do you snore?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never

4. Has anyone noticed that you quit breathing during your sleep?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never

5. How often do you feel tired or fatigued after your sleep?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never

6. During your waketime, do you feel tired, fatigued or not up to par?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never

7. Have you ever fallen asleep unintentionally or have to fight to stay awake during the day?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never

8. Have you ever nodded off or fallen asleep while driving a vehicle?

- Yes
- No

9. If yes, how often does it occur?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never

10. Do you have high blood pressure?

- Yes
- No
- Don't know

Please complete the following:

Height _____
Weight _____
Age _____
Male/ Female? _____

Physician Scoring:

Any "yes" answer = Positive Response

Any first two of the multiple answers = Positive Response

3 or more Positive Responses indicates a high likelihood of sleep disordered breathing. Consider further evaluation.

Name: _____ Date: _____