Obstructive Sleep Apnea Assessment

This questionnaire is a tool to screen for sleep-related breathing problems, or obstructive sleep apnea. It is not a substitute for a sleep disorder evaluation by a qualified physician. However, it can help you identify key factors in your sleep habits that may contribute to obstructive sleep apnea.

*If you answer “Yes” to any of these questions, please discuss your symptoms with your health care provider.*

**Please answer the following questions:**

1. Do you snore or have you been told that you snore?  
   - Yes  
   - No

2. Have you been told that you appear to hold your breath while asleep?  
   - Yes  
   - No

3. Do you experience awakenings from sleep with a snort or cough, choking or shortness of breath?  
   - Yes  
   - No

4. Do your awakenings most often occur when you are sleeping on your back?  
   - Yes  
   - No

5. Is your sleep disturbed by heartburn, reflux or an acid/sour taste in your mouth?  
   - Yes  
   - No

6. Do you awaken from sleep with a headache?  
   - Yes  
   - No

7. Do you avoid sleeping on your back because it’s hard to breathe?  
   - Yes  
   - No

8. Are you currently overweight?  
   - Yes  
   - No

9. Is your neck size greater than 17 inches if you’re a male or greater than 16 inches if you’re a female?  
   - Yes  
   - No

10. Do you frequently awaken with a dry mouth?  
    - Yes  
    - No

11. Are you excessively sleepy during the day?  
    - Yes  
    - No

12. Do you fight sleepiness while driving?  
    - Yes  
    - No

13. Do you have high blood pressure?  
    - Yes  
    - No

*Remember, if you have answered “Yes” to any of these questions, please discuss your symptoms with your health care provider.*