Sleep Apnea Screen

Name _____ **Age** ____ **Date** _____

	Yes	No
Snoring Do you snore loudly?	_____	_____
Tired Do you often feel tired, fatigued, or sleepy during daytime?	_____	_____
Observed Has anyone observed you gasping or stop breathing during sleep?	_____	_____
Blood pressure Do you have or are you being treated for high blood pressure?	_____	_____
BMI BMI > 35	_____	_____

Screen Results:

☐ **Positive Screen**

If the answer is "yes" to 2 or more of the above questions.

☐ **Positive Screen**

BMI > 40

☐ **Negative Screen**